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Communities of Practice as a Knowledge Translation and Exchange Strategy: A Qualitative Secondary Ethnographic Analysis

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Abstract

This study was a secondary qualitative analysis that used the constructivist paradigm and an ethnographic approach to explore the culture and success factors of two Communities of Practice (CoPs). The CoPs, housed by the Seniors Health Knowledge Network (SHKN), worked in wound care and complex care resolution for older adults. Five themes emerged through data analysis: 1) Hope and Desire to Cause Real, Effective Change, 2) Appreciation for Bringing Together Diverse People and Experiences, 3) Aspiring to Work Together as a Harmonious Team, 4) Striving for Strong Work Ethic and Good Practices to Achieve Efficiency and Productivity and 5) Tensions, Worries and Uncertainty. The themes are discussed in relation to CoP literature to suggest strategies for developing, running and sustaining successful CoPs in the realm of healthcare. The most important implication of this work is that passion, work ethic, diversity and communication may help CoPs achieve harmony and success.

Keywords

Secondary Qualitative Analysis, Constructivism, Ethnography, Communities of Practice, Culture, Knowledge Translation

Dedication

To:

Papa, for being the prime motivation for anything and everything I do,

Khalid Uncle, for being the brightest light in my life,

and Aisha, for being you.

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When I reflect back upon the last two years, I realize how I have changed and grown as a student, researcher and person, all due to the mentorship and support of several individuals in my academic and personal circles.

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Chapter 1

1 Introduction

This chapter begins with a definition of knowledge translation in relation to healthcare delivery. It also provides background regarding older adults' health and an introduction to the Seniors Health Knowledge Network (SHKN), which housed the Communities of Practice (CoPs) in this study. The chapter concludes with stating the study's purpose and discussing its significance.

1.1 Knowledge Translation (KT)

Healthcare systems constantly work on improving service quality. However, there is a significant gap between evidence derived through research findings and the use of these findings in healthcare policy and practice (Armstrong, Waters, Crockett, & Keleher, 2007; Davis et al., 2003; Graham et al., 2006; Straus, Tetroe, & Graham, 2011; Tetroe et al., 2008). Although there is knowledge and research available to be incorporated in health practice, this evidence is under-utilized (Armstrong, Waters, Crockett, & Keleher, 2007; Davis et al., 2003; Graham et al., 2006; Straus, Tetroe, & Graham, 2011; Tetroe et al., 2008). Continuing education and professional development for healthcare professionals may not always be effective in bridging this gap (Davis et al., 2003). This knowledge-to-action (KTA) gap may be bridged through employing knowledge translation (KT) initiatives and strategies.

> The Canadian Institutes of Health Research (CIHR) defines knowledge translation as
>
> a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system. This process takes place within a complex system of interactions between researchers and knowledge users which may vary in intensity, complexity and level of engagement depending on the nature of the research and the findings as well as the needs of the particular knowledge user. (CIHR, http://www.cihr-irsc.gc.ca/e/29418.html) (see Appendix A for a detailed definition of knowledge translation).

Bridging the knowledge-to-action gap may help avoid wasting valuable resources, provide the best possible care to patients as well as make better informed decisions regarding care delivery, policy and systems (Armstrong, Waters, Crockett, & Keleher, 2007; Davis et al., 2003; Graham et al., 2006; Straus, Tetroe, & Graham, 2011; Tetroe et al., 2008).

The concept of knowledge translation emerged from the idea of evidence-based medicine (Kothari & Armstrong, 2011; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). Evidence-based medicine can be defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine involves integrating individual clinical experience with the best available external clinical evidence from systematic research" (Sackett et al., 1996, p. 71). In relation to evidence-based medicine, knowledge translation efforts have, until recently, focused mainly on the medical field in terms of healthcare providers making treatment-related decisions for patients (Kothari & Armstrong, 2011). More recently, knowledge translation is beginning to play a role in other areas of the healthcare system such as policy-making, patient education and knowledge transfer and exchange between community-based organizations (Kothari & Armstrong, 2011).

Knowledge translation is a context-specific and non-linear process (Kothari & Armstrong, 2011). It is an interactive and iterative process between the producers of knowledge (for example, researchers) and the end users of the generated knowledge (for example, clinicians, patients or policy makers) (Kothari & Armstrong, 2011). Health-related problems are complex in nature and therefore "require complex solutions involving input from individuals with different expertise and perspectives and iterative, generative processes to formulate, execute, and evaluate solutions" (Kothari & Armstrong, 2011, p. 1). The fact that the process of generating and using knowledge to solve complex health problems involves various stakeholders means that collaboration and partnership are vital to successful KT initiatives (Gagliardi, Berta, Kothari, Boyko, & Urquhart, 2016). Partnership and collaboration should ideally be present throughout the entire knowledge translation process ranging from knowledge generation to knowledge use (Gagliardi et al., 2016). This concept of involving stakeholders through partnership and collaboration for KT purposes is referred to as integrated knowledge translation (IKT) (Gagliardi et al., 2016).

Gagliardi and colleagues (2016) conducted a scoping review of the research that has evaluated various IKT approaches. They summarized enablers and barriers to IKT from their analysis. Although this scoping review was specifically conducted regarding IKT, the identified enablers and barriers are transferrable to knowledge translation in general. Enablers of (integrated) knowledge translation include frequent interaction between stakeholders in the KT process, the involvement of skilled experts providing leadership, agreed-upon goals, the availability of resources such as funding, adequate facilitation amongst various stakeholders and an overall sense of openness between stakeholders (Gagliardi et al., 2016). According to Gagliardi and colleagues (2016), barriers to KT include different individual priorities, "lack of skill in or understanding of IKT processes" (p. 7), not recognizing the value of research, unclear goals and expectations, and lack of resources such as funding and infrastructure.

1.2 Older Adults' Health and the Seniors Health Knowledge Network

Canada has seen a significant increase in the population of older adults over the last few years. A systematic review conducted by Gougeon, Johnson and Morse (2017) reported that currently, older adults over the age of 65 comprise over six million (16%) of all Canadians. According to the Canadian Medical Association (2016), for the first time in Canadian history, 2015 brought about a larger population of older adults (over the age of 65) than children aged 0 to 14 years. With a life expectancy of over 80 years for both men and women in Canada, the number of older adults is expected to rise dramatically within the next couple of decades to make up approximately a quarter of the entire population (Conklin et al., 2011). The later stages in life bring about complex health issues for individuals, for example, stroke, arthritis, dementia, cardiovascular disease, diabetes and other chronic conditions (Conklin et al., 2011; Gougeon et al., 2017). Therefore, a large population of older adults has significant implications regarding healthcare and the health system (Conklin et al., 2011; Gougeon et al., 2017). There is a need for thoughtful decisions regarding care delivery for older adults. For example, older patients often experience longer-than-necessary visits in the hospital for conditions or issues that can be managed more effectively in a long-term care setting or the patient's home (Gougeon et al., 2017). However, the transition from acute care to a long term setting requires an interdisciplinary, team-based approach that involves professionals such as clinicians, nurses, physiotherapists, occupational therapists, social workers and dieticians (Gougeon et al., 2017).

Consequently, the government and healthcare jurisdictions in not only Ontario but all over Canada are working towards the development of an effective system for addressing the healthcare concerns of the aging population (Conklin et al., 2011; Gougeon et al., 2017).

The Seniors Health Knowledge Network (SHKN), previously known as the Seniors Health Research Transfer Network (SHRTN), was launched in 2005 (SHKN, http://shrtn.on.ca/seniors-health-knowledge-network). SHKN is an example of a collection of initiatives working towards improving the health and care delivery, through knowledge translation and exchange, for older adults in Ontario. One of the main goals of SHKN is to facilitate and promote knowledge translation among healthcare providers working in geriatric settings (SHKN, http://shrtn.on.ca/seniors-health-knowledge-network). "SHKN promotes KT through a library service, knowledge brokers, local implementation teams, collaborative technology, and CoPs" (Kothari, Boyko, Conklin, Stolee, & Sibbald, 2015, p. 2). SHKN supports CoPs within various niches related to older adults' care such as falls prevention, advance care planning, at-risk older drivers, nutrition, oral health, dementia, wound care, complex care as well as aging and developmental disabilities (SHKN, http://shrtn.on.ca/shkn-communities-of-practice). The SHKN CoPs consist of over 8000 members who work on knowledge translation efforts by identifying gaps and potential areas of improvement in care delivery and utilizing both research evidence and practitioners' experiential knowledge to implement changes in order to better serve the healthcare needs of Ontario's older adults (SHKN, http://shrtn.on.ca/seniors-health-knowledge-network). SHKN pursues its vision of improving the health of older adults through employing values such as "collaboration, excellence, leadership, stewardship, evidence-based [practices], innovation, [and] respect" (SHKN, http://shrtn.on.ca/seniors-health-knowledge-network). They attempt to meet this goal by seeking out and utilizing appropriate evidence, "fostering organizational change", "facilitation", "integrating quality improvement" and promoting "partnership and collaboration" (SHKN, http://shrtn.on.ca/). At the time of data collection, SHKN received large multi-year grants from the province and then disbursed these funds to CoPs and others primarily as project grants (SHKN, http://shrtn.on.ca/). SHKN has employed evaluative measures such as (annual) evaluation reports to look at researchers' and policy makers' awareness of SHKN, whether knowledge and innovation are being fostered, and monitor SHKN's progress to ensure that goals are being met. The Executive Director of the network also produces a Network Annual Report (SHKN, http://shrtn.on.ca/shkn-network-evaluation).

SHKN's evaluative methods include "document and website review, key stakeholder interviews, analysis of surveys and performance data collected during the year, survey of network members [and] other approaches that fit the Network goals and activities" (SHKN, http://shrtn.on.ca/shkn-network-evaluation). "Since its launch... SHKN has become a significant knowledge transfer network linking Ontario caregivers, policymakers, and researchers who focus on improving the care of seniors" (Kothari et al., 2015, p. 3).

1.3 Study Purpose

The purpose of this study was to explore the cultural values and success factors of CoPs according to their members. This study took an ethnographic approach to analyze secondary qualitative data in order to explore aspects of culture and success factors from the perspective of the members of two CoPs within the SHKN. The two CoPs explored in this study focused on wound care (designated as the "Firefly" CoP[1]) and complex care resolution (designated as the "Mulberry" CoP[1]). The study objectives and research questions are stated and discussed further in the Study Objectives and Research Questions section under Chapter 2, the Literature Review.

1.4 Significance

The findings from this study have significance in the areas of: 1) conducting secondary qualitative research, 2) understanding the culture and enablers of CoPs as well as 3) their potential influence on health services in the areas of wound care and complex care resolution for older adults.

As a qualitative secondary ethnographic analysis, this study provides an example of secondary qualitative analysis conducted in relation to the health sector. As there is limited direction in the literature regarding secondary qualitative analysis (Corti & Bishop, 2005), this study may be used as a beginning point and may provide some guidance to future secondary qualitative research, especially if a researcher/team is conducting a constructivist ethnography. With a transparent process of analyzing data, this study outlines secondary analytical techniques. It also

[1] The identities of the CoPs have been changed to ensure confidentiality.

demonstrates the strengths and drawbacks specific to a secondary ethnography, which may be used in the future for learning purposes and developing study protocols for secondary qualitative research.

The ethnographic approach proposed for this study allows for a unique look at CoPs and a different perspective in terms of their culture and values. We conducted this secondary analysis with the assumption that CoPs do indeed have culture and that their values may or may not be unitary. The concept of culture, for the purpose of this study, is defined and discussed further in Chapter 2. The findings demonstrate similarities and differences between the two CoPs in terms of their experiences and values. Attempting to understand the workings and culture of CoPs from diverse perspectives using diverse data has the potential to be useful and significant because it can suggest insights for developing and maintaining successful health-related CoPs. Although the results from this study cannot be generalized to all CoPs, the diverse perspectives regarding the research questions may be relatable for other CoPs in different and similar contexts. This may allow for brainstorming ideas regarding improvement of CoPs and consequently better functionality.

This study contributes to understanding the culture, workings and values of CoPs. Therefore, the findings may help work towards recommendations to improve CoPs and related KT initiatives. This is important because CoPs are a relatively novel KT strategy and require more understanding (Kothari et al., 2015). A better understanding of the CoPs analyzed in this study can assist in incorporating diverse perspectives and various kinds of evidence in the care of older adults. In general, better functioning CoPs may result in better context- and case-specific care delivery, improving the overall efficiency of the healthcare system for older adults.

Chapter 2

2 Literature Review

This chapter begins with an introduction of Communities of Practice as described by Wenger's theory (Wenger, 1998; Wenger, 2011). It provides background regarding the history and evolution of the concept of CoPs, their use of explicit and tacit knowledge, their facilitators and barriers, along with their role within the realm of healthcare. Next, we've discussed the notion of culture in relation to healthcare teams and organizations, along with the concept of secondary analysis within qualitative research. The chapter concludes with stating the study objectives and research questions posed in relation to the data.

2.1 Communities of Practice as a Knowledge Translation Strategy

There are various types of initiatives, models and strategies that can be employed for the purpose of translating research into applicable and useable knowledge. For example, a healthcare organization can distribute information to patients through a campaign or educational documents in laypersons' language. Another example of a KT strategy is knowledge brokers who bridge gaps between knowledge producers (for example, researchers) and users (for example, clinicians) (Conklin, Lusk, Harris, & Stolee, 2013; Dobbins et al., 2009). On a more interactive level, another KT initiative is a community of practice (CoP). According to Wenger (2011), "communities of practice are formed by people who engage in a process of collective learning in a shared domain of human endeavor...[they] are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly" (Wenger, 2011, p.1). Wenger (2011) further breaks down the CoP concept into "the domain", "the community" and "the practice" (p. 1).

The domain aspect refers to the fact that all members of a CoP share similar interests within a particular topic/domain and have distinguished skills and expertise directly related to the domain (Wenger, 2011). These skills and expertise can be profession-specific or contextual and those external to the CoP may not be aware of or recognize the expertise and knowledge possessed by its members (Wenger, 2011). Regardless, members of a CoP are aware of each other's expertise

as well as the value of the CoP as a whole, and therefore are constantly learning from each other (Wenger, 2011).

The community aspect of a CoP refers to the notion of members working together in order to accomplish goals within the domain of interest. This occurs through sharing information, discussing issues and collectively conducting activities (Wenger, 2011). A highly important part of the community aspect of a CoP is the formation of relationships between the members (Wenger, 2011). An open relationship among CoP members allows for interaction to share information and learn together (Wenger, 2011). It is important to note that although members of a CoP need to interact in order to accomplish goals, there is no determined frequency of regular meetings (Wenger, 2011). For example, a trauma surgery CoP may include various members such as surgeons, physicians, researchers and knowledge brokers. Although these individuals compose a CoP, their work schedules and commitments may not allow for daily or regular meetings. Hence, CoPs have traditionally been self-organized, informal entities functioning in formal settings and often may not explicitly declare themselves as CoPs (Meagher-Stewart et al., 2012; Wenger, 1998); a recent trend however is to deliberately organize CoPs, like SHKN has, to address issues.

The practice aspect of a CoP refers to the fact that members are "practitioners" within the domain of interest (Wenger, 2011). "They develop a shared repertoire of resources: experiences, stories, tools, ways of addressing recurring problems—in short a shared practice [that] takes time and sustained interaction" (Wenger, 2011, p. 1). Wenger (2011) states that a CoP may not always be formed consciously, especially in the healthcare field. For example, physicians and nurses who discuss medical cases during their free time are cultivating and sharing information and knowledge with each other with the goal of improving care for their patients (Wenger, 2011). This occurs through sharing instances and stories about cases; these stories "become a shared repertoire for their practice" (Wenger, 2011, p. 1). However, since CoPs are often formed unconsciously, the shared goals may not be objectively stated (Wenger, 1998).

Therefore, the domain, community and practice aspects not only form a community of practice, but they also need to be constantly developed, iteratively, in order to sustain a CoP (Wenger,

2011). According to Li et al. (2009b), the literature is not very clear regarding how to exactly develop these aspects together, especially when a CoP is first formed.

2.1.1 History and Evolution of the Concept of CoPs.

The idea of a community of practice initially came from Lave and Wenger; according to them, learning does not (entirely) occur through acquiring knowledge in a conventional sense, but rather through social interaction and relationships (Roux, Rogers, Biggs, Ashton, & Sergeant, 2006; Wenger, 2011). Lave and Wenger demonstrated this by illustrating how individuals in various professions such as midwifery, tailoring and butchering share and learn knowledge (Lave, 1991; Lave & Wenger, 1991; Smith, 2003). They explained that much of the learning occurred through informal sharing of stories and experiences in information meetings and gatherings. An open learning environment allowed inexperienced trade members to learn from experts, and for everyone to identify problems and propose solutions within the domain of interest (Lave, 1991; Lave & Wenger, 1991; Smith, 2003). Over time, practices were refined and improved and this informal way of communicating, sharing and learning became the primary means for improving individual skills and the overall trade (Lave, 1991; Lave & Wenger, 1991; Smith, 2003). The observations made by Lave and Wenger lead to the emergence of the situated learning theory, which is applicable in several fields and states that knowledge is not separate from practice as learning knowledge and applying it occur simultaneously in space and time (Lave, 1991; Lave & Wenger, 1991; Smith, 2003). Once Lave and Wenger coined the term after examining apprenticeships as learning systems, they noticed the presence of CoPs everywhere (Lave, 1991; Lave & Wenger, 1991; Smith, 2003). Most of these CoPs were not intentional or self-aware as a functioning body (Wenger, 2011). Wenger and Lave also noticed that it is not necessary for a CoP to contain novices as all trades require constant learning by all individuals including experts (Wenger, 2011).

Wenger also proposed that mutual engagement, joint enterprise and a shared repertoire act as interconnected dimensions in a community of practice (Wenger, 2011). Mutual engagement refers to the generation of shared meaning as a result of interaction between individuals of a team. Joint enterprise refers to individuals engaging and working together for a common purpose/goal, and a shared repertoire refers to the specific language, vocabulary, stories and

resources used by members of a CoP to communicate ideas, information, knowledge and meaning (Wenger, 2011).

In the past, CoPs have been explicitly recognized in the business and educational sectors (Bezyak, Ditchman, Burke, & Chan, 2013; Piat, Briand, Bates, & Labonté, 2015; Ranmuthugala et al., 2011). However, CoPs can be found in all fields and settings featuring an aspect of practice and expertise within a domain (Bezyak, Ditchman, Burke, & Chan, 2013; Gabbay & le May, 2011). The definition of CoPs in relation to the health sector has evolved since its origin (Li et al., 2009a; Ranmuthugala et al., 2011; Seibert, 2015). There has been a change in perception regarding CoPs as they have shifted from an organic entity to a deliberate strategy for knowledge translation and exchange for the purpose of improving healthcare delivery (Bezyak, Ditchman, Burke, & Chan, 2013; Li et al., 2009a; Moodie et al., 2011). Although CoPs have always been present informally, they are becoming more formally acknowledged as strategies used for sharing practice and research knowledge within the healthcare field (Bezyak, Ditchman, Burke, & Chan, 2013; Cox, 2005; Li et al., 2009a; McKellar, Pitzul, Juliana, & Cole, 2014; Briand, Bates, & Labonté, 2015). Nevertheless, members of a CoP generally end up participating due to their interest in a field or area of expertise, as opposed to obligation (Bezyak, Ditchman, Burke, & Chan, 2013). The perception of CoPs has also evolved to include virtual forms, especially with advances in technology such as online networks and social media platforms (Bezyak, Ditchman, Burke, & Chan, 2013). Furthermore, the perception of CoPs is now shifting away from focusing on practitioners and researchers in order to include other healthcare stakeholders such as patients, service users and any other consumers or contributors of knowledge in a specific domain (Bezyak, Ditchman, Burke, & Chan, 2013; Thomson, Schneider, Wright, 2013). "In this way, CoPs have the potential to be a useful tool for promoting and embodying knowledge translation while at the same time promoting the ethical considerations related to promoting consumer empowerment, voice, and choice" (Bezyak, Ditchman, Burke, & Chan, 2013, p. 93).

2.1.2 Explicit and Tacit Knowledge.

Members within a healthcare CoP not only use explicit knowledge, but also rely heavily on tacit knowledge to improve care for patients (Li et al., 2009b). Explicit knowledge is codified or

written knowledge and usually obtained through scientific research and literature (Kothari et al., 2012). Explicit knowledge "is subject to quality control by editors, peer review and debate and given status by incorporation into educational programmes, examinations and courses. [Explicit knowledge] includes propositions about skilled behaviour" (Eraut, 2000, p. 113-114). According to Eraut (2000), actual skill development occurs through acquiring tacit knowledge. Tacit knowledge refers to that which is acquired through extensive personal experience within a field/domain. It is "the cognitive resource which a person brings to a situation that enables them to think and perform" (Eraut, 2000, p. 114). Knowledge translation in general and CoPs specifically both face the challenge of integrating various types of explicit and tacit knowledge in healthcare endeavours (Li et al., 2009b). In communities of practice, healthcare professionals have the opportunity to not only share the explicit knowledge provided by their training, but also include tacit knowledge acquired through their own experiences. Sharing tacit knowledge within a CoP contributes to improving care delivery by making it more context-specific within the domain of interest (Li et al., 2009b).

Tacit knowledge plays an important role in professionals and teams providing the best possible healthcare. Gabbay and le May (2004) conducted a study to explore the knowledge-related practices of health practitioners and nurses. According to Kothari et al. (2012), Gabbay and le May's (2004) findings suggest that knowledge is "negotiated and co-constructed" (Kothari et al., 2012, p. 3) for the purpose of collective decision-making. The authors reported that the health professionals in the study used "mindlines" while providing care to patients (Gabbay & le May, 2004). Although these mindlines utilized explicit knowledge, they relied more heavily on tacit knowledge acquired by the professionals through past experiences and discussion with colleagues rather than exclusively on best practice guidelines or research findings (Gabbay & le May, 2004). This demonstrates the importance of discussion and sharing knowledge and stories within a healthcare CoP attempting to make team-based decisions for delivering care to patients.

2.1.3 Facilitators and Barriers.

There are various facilitators and barriers that may affect the success of a community of practice. Since CoPs consist of various members from different backgrounds working together, good professional relationships are an important facilitator for CoPs. If a CoP encourages and supports

an honest and open social environment with a goal to improve care delivery, it is more likely to succeed in achieving said goal (Gannon-Leary & Fontainha, 2007; Gravel, Légaré, & Graham, 2006; Guldberg & Mackness, 2009; Tarmizi, de Vreede, & Zigurs, 2006). Seeing positive results (for example, an improvement in health outcomes) can also boost the confidence of members in a CoP and motivate them to continue working towards delivering better services (Gannon-Leary & Fontainha, 2007; Gravel, Légaré, & Graham, 2006; Guldberg & Mackness, 2009; Tarmizi, de Vreede, & Zigurs, 2006). Technological advances can also act as a significant facilitator for CoPs (Gannon-Leary & Fontainha, 2007; Gravel, Légaré, & Graham, 2006; Guldberg & Mackness, 2009; Tarmizi, de Vreede, & Zigurs, 2006). For example, due to busy schedules and the nature of CoPs, members do not necessarily hold meetings specifically to share information and knowledge. However, they can use various technologies to carry out their purpose. If certain members of a CoP are geographically distant, they can arrange virtual meetings for discussion. Members can also share experiences and stories over lunch/coffee breaks, through informal conversation, email, online common portals or other avenues specific to a CoP. Another strategy within CoPs that can contribute to their success is the use of facilitators such as knowledge brokers (Dobbins et al., 2009, Li et al., 2009b). According to the systematic literature review conducted by Li and colleagues (2009b), there is no one definition of the role of facilitators in CoPs as they can hold different responsibilities. For example, some facilitators work under the supervision of a leader within the CoP; on the other hand, facilitators can also be the actual leaders of a CoP (Li et al., 2009b). Facilitators can be a significant benefit to CoPs as they bridge gaps between individuals and help foster solutions when problems arise.

Although facilitators can be beneficial to CoPs, facilitator fatigue (for example, facilitators losing motivation and becoming overwhelmed with workload) has been shown to be a barrier to the success of a CoP (Pereles, Lockyer, & Fidler, 2002). Another barrier with respect to CoPs is power relationships within them (Li et al., 2009b). There are bound to be individuals or components that are more powerful than others in a CoP. For example, the opinions of physicians, health authority personnel, nurse practitioners and highly experienced nurses are often considered more valuable than those of less experienced members of a team (Li et al., 2009b). Such hierarchy of power may cause some voices to be heard more than others, which may push the activities and decisions in a particular direction. At the same time, the voices of more experienced experts may naturally be more prominent. Therefore, this may not be a

significant issue for "mentor-mentee or expert-novice" relationships, but may be a significant barrier in more complex CoPs (Li et al., 2009b). Although one assumes that CoPs are working towards a common goal of improving care, personal values and agendas can pose a threat to their success (Li et al., 2009b). Power imbalances can also cause the powerful to stay in charge, which may prevent other members from contributing to the CoP and merely remain learners/followers, unable to take on leadership roles. Such barriers may have a negative impact on the effectiveness of a CoP as an evidence-informed decision making system if not addressed adequately.

2.1.4 Significance to the Health Sector.

Communities of practice formally emerged within the healthcare field in the mid-1990s (Li et al., 2009b). The CoP concept has been highly prevalent in the sub-field of occupational therapy and nursing within the broader realm of healthcare (Li et al., 2009b). The term "communities of practice" started gaining popularity with the health and medical literature in the early 2000s. This resulted from "Parboosingh publish[ing] an opinion article discussing the use of CoP groups to facilitate continuing professional development for physicians" (Li et al., 2009b, p. 4) as well as Winkelman and Choo's suggestion to use a CoP "as an intervention for patient empowerment" (Li et al., 2009b, p, 4). Parboosingh (2002) proposed that CoPs can foster professional development for physicians because they "interact with peers and mentors to frame issues, brainstorm, validate and share information, make decisions, and create management protocols, all of which contribute to learning in practice" (p. 230). Winkelman and Choo (2003) suggested that disease-specific communities (of practice) could be introduced by healthcare organizations in order to facilitate knowledge creation, acquisition and use by chronic patients. Patients can use these communities of practice to share knowledge gained from the experience(s) of living with a chronic condition. The opportunity to share personal knowledge with individuals experiencing similar circumstances changes the role of patients from healthcare consumers to empowered members of a community (Winkelman & Choo, 2003).

A CoP can take various forms within the healthcare field (Bezyak, Ditchman, Burke, & Chan, 2013). A systematic review conducted by Li and colleagues (2009b) examined different health-related CoPs. They included "clinical placements where students interacted with and learned from expert practitioners, informal learning groups (e.g., journal clubs), health care agency

collaboratives that aimed to achieve a common goal (e.g., to improve primary care for older people), and virtual communities where practitioners from different sites discussed work related issues" (Li et al., 2009b, p. 5). Li and colleagues (2009) found that CoPs were not only used as a strategy to facilitate students' learning from experts and developing professional identities, but they were also used as a strategy to share information and knowledge for the purpose of professional development and better healthcare delivery. As opposed to CoPs within the business sector, health-related communities of practice tend to focus on facilitating positive social interaction and forming relationships, mostly in person "at the workplace or during task-oriented activities" (Li et al., 2009b, p. 5), but sometimes also through the use of information technology and virtual meetings/discussions (Li et al., 2009b). Lastly, since there are so many factors at play within a CoP and due to the fact that CoPs are a relatively new concept in healthcare research, Li and colleagues (2009b) could not arrive at a concrete conclusion regarding the effectiveness of CoPs within the health sector and emphasize the need for evaluative measures. McKellar, Pitzul, Yi, and Cole (2014) conducted a systematic scoping review regarding CoP evaluation frameworks; they also determined that "there is little agreement on approaches to evaluate the influence and effectiveness of CoPs" (p. 383) and that "there is a need for more detailed and targeted CoP evaluation frameworks" (p. 383).

2.2 Professional and Organization Culture in Healthcare

Since this study took an ethnographic approach to examine CoPs, culture is a vital concept for consideration (Rashid, Caine, & Goez, 2015). Culture as a phenomenon is exceptionally difficult to define and, therefore, there is no universal definition of culture (Rashid et al., 2015). However, conventionally, anthropologists generally use the term culture "to refer to ideas, attitudes, values, and so on learned by humans in the course of growing... in a particular community and affecting the way people behave" (Rashid et al., 2015, p. 12). For the purpose of this study, values are what individuals consider important to themselves, other individuals, ideas, things and actions (Saldana, 2009). As reported by Saldana (2009), attitudes, which are formed and learned over time with experience, are how individuals think about themselves, other individuals, ideas, things and actions. Beliefs are "part of a system that includes our values and attitudes, plus our personal knowledge, experiences, opinions, prejudices, morals, and other interpretive perceptions of the

social world" (Saldana, 2009, p. 89). Values, attitudes and beliefs are all interconnected and affect each other to form an individual's cultural identity.

The definition of culture in relation to ethnographic research has evolved over time (Rashid et al., 2015). Traditionally, ethnographers used to look at culture in a broader sense; they looked to explore concepts such as language, ethnicity and religious nuances (Rashid et al., 2015). Recently, the focus has shifted towards exploring sub-cultures and cultures within cultures (Rashid et al., 2015). Healthcare-related ethnographic research has also shifted towards looking at culture within more specific contexts (Rashid et al., 2015).

The presence and implications of culture on our worldviews, beliefs and actions is undeniable. Culture is present in every aspect of life, whether that is religious practices, food preferences, sexuality or a healthcare group/setting such as physicians, nurses, a hospital, long-term care facility or a community of practice (Khokher, Bourgeault, & Sainsaulieu, 2009). In the past few decades, globalization and the movement toward a patient-centered approach to healthcare have placed high importance on culture and context. In the healthcare sector, culture exists among individual professionals and teams as well on a larger scale among organizations (such as hospitals) (Khokher et al., 2009).The cultures of healthcare professionals and hospitals are related as they both influence each other (Khokher et al., 2009). Professional culture refers to culture that is a result of healthcare professionals' experiences with colleagues, training programs and socialization at the workplace (Irvine, Kerridge, McPhee, & Freeman, 2002). Professional culture includes characteristics such as use of specialized language, professional identity and sharing of intellectual ideas based on training and past experience (Khokher et al., 2009). Professional culture can act as a barrier in regards to interprofessional collaboration among various types of healthcare professionals/teams due to differences in opinions and beliefs about practices as well as assumptions about status and power (Khokher et al., 2009). On a larger scale, organizational culture can also have a significant effect on the behaviour, activities and interests of healthcare professionals working in a hospital setting (Khokher et al., 2009). Aspects of professional culture can exist independently of organizational culture (Montgomery, 1997). However, this may be the cause of tensions and disagreements if there are significant differences between the values, beliefs and goals of the organization compared to its professional staff (Khokher et al., 2009). Such barriers can also contribute to resistance against change in a

healthcare organization (Bacigalupo, Hess, & Fernandes, 2009). Therefore, organizational and professional culture not only influence each other, but the interplay between them also has a larger-scale impact on organizational performance and overall healthcare delivery (Khokher et al., 2009).

The concept of context holds importance in relation to the phenomenon of culture. Attention to culture and context during an initiative within an organization may be vital for the success of the initiative, and consequently the organization (Mugisha, 2009). For example, Mugisha (2009) explored continuing professional development in healthcare organizations in relation to context and culture. According to Mugisha (2009), continuing professional development is intertwined with organizational performance and both concepts are significantly impacted by context. Continuing professional development "is likely to be a more effective tool for supporting organisational performance in organisations where there is a culture that is receptive and adaptive to learning, and supportive of change, performance measurement, flexibility and innovation" (Mugisha, 2009, p. 56). Some other cultural aspects that Mugisha (2009) described as success factors for health professional development are peer support, team spirit, an environment that supports learning, involved management and leadership, as well as a "positive attitude to change and innovation" (p. 57); some of these elements may arise in effective CoPs.

Khokher and colleagues (2009) conducted a study looking at the perspectives and experiences of healthcare professionals regarding the workplace culture in different healthcare units in a hospital. Khokher and colleagues (2009) also explored the role of patients in the healthcare professionals' perception of their work culture. This study demonstrates the fact that different contexts, even within a hospital setting, have different implications regarding culture amongst professionals and between professionals and patients (Khokher et al., 2009). For example, nurses working in open units (characterized by high, uncontrollable patient flow and high staff turnover, e.g., the emergency room or the maternity ward) reported difficulty in fostering prolonged and meaningful interaction with patients due to a lack of time spent with them (Khokher et al., 2009). In closed units (characterized by fewer patients with longer stays, such as intensive care), although patients were not always conscious or able to interact, nurses reported a culture of treating them with respect and dignity and taking extra initiative to sustain interaction, regardless of reciprocation (Khokher et al., 2009). Contrary to nurses, physicians reported the sense of

being resources for their patients in terms of providing explanations and information regarding their condition or disease (Khokher et al., 2009). Overall, physicians reported a culture of pleasant interactions with patients, especially on the face-to-face level; they reported that although patients were not always satisfied with their services, they still seemed appreciative and pleasant due to the power imbalance between physicians and patients (Khokher et al., 2009). Some of these cultural values and beliefs such as a sense of care for patients' well being may be present in the culture of a CoP as well.

Not only did Khokher and colleagues (2009) look at culture between professionals and patients, but they also explored culture amongst professionals. For example, in the intensive care unit, professionals reported experiencing a culture of equality and appreciation, teamwork and a supportive atmosphere among different individuals such as physicians and nurses. There was mutual respect among the intensive care professionals with an openness to learn from each other regardless of professional status (Khokher et al., 2009). The presence of mutual respect and trust, as cultivated in a successful CoP, is important for a professional and organizational culture that is ready to adopt change in order to improve professional and organizational performance (Bacigalupo et al., 2009). Contrary to intensive care, units such as maternity and emergency reported a cultural atmosphere of more unhealthy conflict (e.g., political maneuvering for personal agendas) and the existence of cliques stemming from factors such as varying lengths of work experience (Khokher et al., 2009). The fact that Khokher and colleagues (2009) found differences between different aspects of culture in open versus closed units verifies the notion that context plays a significant role in the culture of a health-related group or setting.

The culture of leadership within an organization's management affects the organizations' readiness for change and improvement (Bacigalupo et al., 2009). Leaders within organizations (including those that are health-related) must cultivate a culture that accepts the ambiguity of the future (LaMarsh, 1995). An organization's and its professionals' ability to understand that the future is uncertain helps build a change-ready culture and embody the fact that change is vital for improvement (LaMarsh, 1995). However, it is important to note that cultural change is a slow process that can take a significant amount of time (Barriere, Anson, Ording, & Rogers, 2002). Barriere and colleagues (2002) also address the importance of leadership in cultural transformation within a professional setting. According to Barriere and colleagues (2002),

"bringing about a cultural transformation requires that leaders are capable of exhibiting and reinforcing behaviors that are essential to the desired [new] culture" (p. 116). Some cultural changes are automatic, require minimal effort and happen on their own with time. On the other hand, cultural changes may also be initiated by a professional group or organization for the purpose of improving services, products and performance (Barriere at al., 2002). The CoPs in this study focused on KT initiatives that aimed to change certain aspects of healthcare delivery. For example, the Firefly CoP worked on an initiative with the goal of changing how wound care is addressed for older adults during transitions between healthcare settings.

It is important to recognize that individual CoP members are also subject to the cultural pressures that originate in their occupational groups and in their workplaces. For example, a CoP member who is a nurse may be influenced by the culture of the CoP as well as by the culture of the nursing profession along with the culture of the long term care home where he/she works. For the purposes of this study, the key attributes of a CoP's culture were regarded as the ideas, attitudes, values and beliefs expressed by the participants as members of CoPs.

2.3 Secondary Analysis in Qualitative Research

Secondary qualitative analysis involves using existing data to either find answers to novel research questions that differ from those of the primary study, or to understand existing data in a new light (Hinds, Vogel, & Clarke-Steffen, 1997; Irwin, 2013, p. 295). In addition to addressing new questions from previous data, researchers can also use secondary analysis to relate their own primary data and/or findings to existing research (Irwin, 2013). Researchers can also pose new questions of data collected by other researchers and even bring different datasets together for unified analysis (Irwin, 2013). Unlike quantitative secondary analysis, qualitative secondary analysis is not a common practice for the purpose of verifying or refuting previous findings from primary research (Coltart, Henwood, & Shirani, 2013). This notion poses contradictions regarding ontology, epistemology and methodology, especially if the primary qualitative research was conducted through a relativist (such as constructivist or critical theorist) lens (Coltart, Henwood, & Shirani, 2013).

Qualitative secondary analysis has experienced growth within the last few years (Irwin, 2013). In

some instances, for example at the Qualitative Data Archival Resource Centre (Qualidata) at the University of Essex in United Kingdom, researchers may share data through data archives (Irwin, 2013). This means that "qualitative researchers deposit anonymized data which meet standardized archiving requirements relating to its format and ethical consent, for example, and they may themselves require certain conditions be met in allowing access to their data" (Irwin, 2013, p. 295). This act of sharing data contributes to more possibilities and an increasing prevalence of secondary qualitative analysis. Unfortunately, the possibilities of secondary analysis in qualitative research are arguably being underutilized as concerns regarding its potential still exist in the health and social sciences research communities (Irwin, 2013).

There are varying perspectives on the acceptance, or the lack thereof, of qualitative secondary analysis based on its advantages and disadvantages (Irwin, 2013). For example, secondary analysis can be more time-efficient for researchers with difficult research deadlines (Grinyer, 2009; Szabo & Strang, 1997). Factors that may contribute to the time-consuming nature of qualitative research include sampling participants, recruiting them, performing multiple interviews and transcribing data. For a researcher conducting secondary analysis, these stages of the project are often already completed. Time-efficient research can prove highly beneficial in some instances, for example, for researchers with strict program and funding deadlines (see Reflexive Note 2 in Appendix B). Conducting secondary analysis can also prove to be more cost-efficient for researchers, for example through eliminating the need for honorariums or subsidiaries (Szabo & Strang, 1997). This may be a significant benefit as there is more and more competition and difficulty in obtaining funding for research (Szabo & Strang, 1997). Secondary analysis can be beneficial in avoiding under-utilizing data and being sensitive to hard-to-reach, vulnerable populations (Abrams, 2010; Szabo & Strang, 1997). For example, if a study's participants involve dementia patients or their caregivers, secondary analysis can provide the opportunity for related and relevant research to continue without re-interviewing or recruiting additional participants. This allows for the potential of maximally using data and avoiding further inconvenience and stress for research participants (Grinyer, 2009; Szabo & Strang, 1997). In addition to vulnerable participants, this advantage can also be applied in terms of sensitive research topics. For example, if a phenomenological study regarding the lived experiences of sexual assault victims yields rich data, it may be more ethically sound to maximize data use through secondary analysis rather than re-interviewing participants. Lastly,

secondary qualitative analysis can allow for unique collaborations that may not be possible with primary research (Heaton, 2008). For example, qualitative secondary analysis can be a great resource for conducting collaborative, large-scale studies that involve geographically distant locations (Heaton, 2008). For instance, a team of researchers can engage in secondary analysis in an attempt to explore the social phenomenon of homelessness or intimate partner violence and compare findings between two geographically distant locations. They would not necessarily be looking to verify or refute findings between the different locations, but rather gain different perspectives based on cultural, societal and geographic differences (Corti & Bishop, 2005; Heaton, 2008).

On the other hand, secondary qualitative analysis may not allow for a deep relationship between the data and the researcher (Thorne, 1994; Heaton, 2008). There can be significant challenges in contextualizing data while conducting secondary qualitative analysis (Thorne, 1994; Heaton, 2008). Contextualization of data refers to comprehensively understanding the data in relation to the paradigm, methodology and methods that were used in the initial data collection. For a secondary researcher, it is important to understand why certain research measures were chosen over others as well as the context in which data was collected. Perhaps the biggest challenge associated with secondary qualitative analysis is the fact that the data collected may not be in line with the paradigmatic position of the analyst (Thorne, 1994). Therefore, coherence, which refers to using methods that correspond to the researcher's paradigm and chosen methodology (Tracy, 2010), may be relatively much harder to achieve, especially if the secondary analyst did not collect the data. There can also be a sense of lack of control for a researcher conducting secondary qualitative analysis as they may miss out on opportunities present in primary research (Hinds, Vogel, & Clarke-Steffen, 1997). For example, most relativist paradigm researchers emphasize reflexivity, which involves the researcher being transparent about their assumptions prior to starting a study (Finlay, 2002; Tracy, 2010). Qualitative researchers often accomplish reflexivity by utilizing techniques such as keeping detailed field notes, observational notes and reflections based on experiences in the field (Tracy, 2010; Finlay, 2002). Secondary analysis has the potential to significantly limit and/or inhibit the researcher's interaction with the collected data as well as the participants of a study. Since the researcher analyzing data may not be the individual collecting it, they are unable to keep the aforementioned field notes and reflexive accounts. This means that the researcher may not be able to pick up on nuances such as why a

particular participant was more articulate than others, how a setting shaped an interview, and any non-verbal communication with participants (Thorne, 1994). Unfortunately, there is little literature about secondary analysis of qualitative data, which can lead to challenges such as difficulty in determining analytic techniques and being restricted to certain approaches and methods that coincide with the already completed stages of the project (Corti & Bishop, 2005).

Secondary qualitative analysis also presents unique challenges in terms of adequately evaluating the research. Unfortunately, there is not a consensus among the qualitative research community regarding criteria for evaluating qualitative research (Caelli, Ray, & Mill, 2003). This is an even larger issue for secondary qualitative analysis as there is minimal literature regarding its evaluation (Irwin, 2013). Regardless, there are certain criteria that may be applied to qualitative studies in a context-specific manner; these criteria can also help guide the evaluation of secondary qualitative analysis (Tracy, 2010). Tracy (2010) outlines eight criteria that may be used to evaluate qualitative research or conduct an excellent study. Although all eight criteria can be applied specifically to secondary analysis as well, certain criteria (such as rigour, sincerity, adherence to proper ethical practices and an honest attempt at methodological coherence) should be considered closely for secondary qualitative research (Tracy, 2010; Grinyer, 2009). Secondary analysis may be a useful and appropriate avenue for many researchers as all researchers are individuals with complex and context-specific situations and varying realities (Hinds, Vogel, & Clarke-Steffen, 1997) (see Reflexive Notes 1 and 2 in Appendix B).

Researchers and students also have the responsibility to seek out and employ strategies in order to facilitate their secondary qualitative research studies. For example, the researcher should attempt to re-contextualize the data as much as possible, especially if they are working from a relativist position (Corti & Bishop, 2005). Re-contextualization can be achieved through reading supplementary documents, familiarizing oneself with the research question's background and methodology, and speaking to the individuals involved in the primary study or data collection (Corti & Bishop, 2005). Researchers can also engage in deep reflexivity from the beginning of a secondary analysis project. Qualitative researchers often accomplish this by utilizing techniques such as keeping detailed field notes, observational notes and reflections based on experiences in the field (Tracy, 2010; Finlay, 2002). Reflexivity leads to transparency regarding the researcher's beliefs, values and impact on the research (Tracy, 2010; Finlay, 2002). Secondary qualitative

researchers should employ reflexivity and transparency right from the beginning of a research project through to the very end (Tracy, 2010; Finlay, 2002).

2.4 Study Objectives

The aim of this study was to explore communities of practice using an ethnographic approach. We aimed to look at how CoPs are experienced *by* their members in terms of culture (with the assumption that it exists) as well as the barriers and facilitators of success. There is a need for research regarding communities of practice, specifically those in the healthcare sector that are engaging in evidence-informed decision making (Bezyak, Ditchman, Burke, & Chan, 2013; Meagher-Stewart et al., 2012; Roberts, 2015; Turner, 2017). Research regarding key features of CoPs that "are associated with successful translation of evidence into practice" (p. 29) would also contribute to a better understanding of CoPs (Thomson, Schneider, & Wright, 2013). Our study contributes to filling this gap by exploring the culture and success factors of CoPs from the *perspective of the CoP members*.

It is worthwhile to study CoPs and their members' perspectives using an ethnographic approach to uncover culture and social context (Pyrko, Dörfler, & Eden, 2016). According to Pyrko, Dörfler, and Eden (2016), "investigations, possibly of ethnographic design, could possibly lead to a rich portrayal of thinking together in CoPs, with different types or forms of thinking together happening at various stages of the CoP lifecycle" (p. 406). Therefore, this study contributes to the CoP healthcare literature by examining this KT strategy using a novel approach for insights (Bezyak, Ditchman, Burke, & Chan, 2013; Meagher-Stewart et al., 2012; Roberts, 2015).

2.5 Research Questions

Keeping with the ethnographic approach, the research questions for this analysis specifically included culture and the perspective of the participants who were interviewed during data collection. The two specific research questions being posed in relation to the data were:

1. As a member, what culture and values are associated with being part of a CoP?

2. What should a successful CoP look like according to members?

These questions were explored, through a constructivist lens, by secondary analysis of two CoPs using an ethnographic approach. Two older adults' health communities of practice from SHKN were chosen to look for diversity in how individuals experience their CoPs, therefore contributing to the richness of data and research findings and a deeper understanding of CoPs as a phenomena. The rationale for sampling is explained in further detail in the Sampling section under Methodology (Chapter 3).

Chapter 3

3 Methodology and Methods

This chapter begins with an introduction of the parent study that provided the data for secondary analysis in this study. Then, the first author's constructivist worldview is discussed, which is followed by an introduction of ethnography as the methodology employed in this study. Within the discussion regarding ethnography, sampling, data collection and data analysis methods are presented. The chapter concludes with a discussion regarding the employment of reflexivity throughout the research process.

3.1 Situating the Secondary Analysis

This study is a sub-study of a larger three-year parent study that looked at nine CoPs within the Seniors Health Research Transfer Network (now known as the Seniors Health Knowledge Network (SHKN)). The general purpose of the parent study was to explore CoPs working towards improving care delivery for older adults by investigating how they "work and pursue knowledge exchange in different situations" (Conklin et al., 2011, p. 1). The SHKN aims to improve care for older adults living in Ontario, Canada with a focus on knowledge translation (http://shrtn.on.ca). As mentioned earlier, this is accomplished in part by several (approximately 8000) members of CoPs working to translate evidence and research in order to make better, informed decisions about older adults' care (Conklin et al., 2007). This sub-study is a constructivist secondary ethnographic analysis of two particular CoPs within the SHKN, one concerning wound care and the other focusing on complex care for older adults. The aim was to explore the culture of CoPs and what successful CoPs should look like according to their members. Ethics approval was received for the parent study protocol from the Health Sciences Research Ethics Board of Western University (#17879E), Bruyère Continuing Care Research Ethics Board (# M16-11-004), Concordia University Human Research Ethics Committee (# HU2010-115) as well as the University of Waterloo Office of Research Ethics (ORE # 16894).The first author, who conducted the secondary analysis, signed a confidentiality agreement in order to adhere to the ethics protocol.

3.2 A Constructivist Ethnography

The constructivist paradigm "adheres to a relativist position that assumes multiple, apprehendable, and equally valid realities. Essentially, constructivists hold that reality is constructed in the mind of the individual, rather than it being an externally singular entity" (Ponterotto, 2005, p. 129). For a constructivist, social realities are constructions based on society, culture, and life experiences; a physical reality, however, can be shared by more than one individual (Guba & Lincoln, 1994). In terms of epistemology, constructivists believe "the investigator and the object of investigation... to be interactively linked so that the 'findings' are *literally created* as the investigation proceeds" (Guba & Lincoln, 1994, p. 111). The methodology for a constructivist is hermeneutical and dialectical (Guba & Lincoln, 1994). Guba and Lincoln (1994) state that "the variable and personal (intramental) nature of social constructions suggests that individual constructions can be elicited and refined only through interaction between and among investigator and respondents. These varying constructions are interpreted using conventional hermeneutical techniques, and are compared and contrasted through a dialectical interchange" (p. 111).

Ethnography is a qualitative research methodology that concerns the study of a culture and/or group (Huot, 2014). More specifically, researchers conducting ethnographies aim to explore the meanings and definitions that members of a group attribute to concepts and ideas. It is important to note that ethnographies aim to explore the nature of a group and its members, specifically in relation to its historically and socially situated context (Huot, 2014). Since an ethnography looks at how individuals within a group construct relevant realities in relation to context and culture, it is a suitable approach to examine the culture within healthcare communities of practice (Huot, 2014). In this instance, culture does not refer to an idea based on ethnicity, but rather how knowledge and interaction shapes a group's and its members' actions, behaviour and perceptions about the world or a domain of interest (Huot, 2014). For the purpose of this study, culture is defined as a lived phenomenon rather than something that is ideal or objectified. Although ethnographic research has been conducted for many years, the use of this methodology within healthcare is relatively novel (Holloway & Galvin, 2016; Williamson, 2006). Within healthcare, there are more examples of ethnographies conducted from a critical theory lens (Holloway & Galvin, 2016). There is also minimal guidance in the literature about conducting ethnographic

research with an underling constructivist paradigm (Holloway & Galvin, 2016; Williamson, 2006). The amount of guidance regarding specific techniques for secondary ethnographic analysis is even more scarce (Holloway & Galvin, 2016; Williamson, 2006).

There are various types of ethnographies conducted in healthcare including focused ethnographies, critical ethnographies, institutional ethnographies, autoethnographies and visual ethnographies (Rashid et al., 2015). Although the data used in this study was not originally collected for the purpose of a focused ethnography, this study was most similar to this approach than other types of ethnographies. As discussed by Rashid and colleagues (2015), conventional ethnography places emphasis on "long-term fieldwork, prolonged participant observation, and the involvement of larger unknown communities" (p. 9). On the other hand, focused ethnography aims to study a specific, predetermined phenomenon (Knoblauch, 2005; Rashid et al., 2015). It looks to explore individuals' experiences that are "socially and culturally highly fragmented and differentiated" (Knoblauch, 2005, p.1) and looks to explore experiences of a specific group or (sub)culture in a particular setting (Cruz & Higginbottom, 2013). This study resembled a focused ethnography because it had similarities to certain key features of a focused ethnography. For example, focused ethnographies place more weight on collecting and analyzing data as opposed to spending time in the field or observing participants (Knoblauch, 2005). This fit well with our study as there was more data collected from interview transcripts as compared to observation. Focused ethnography also emphasizes the point of view of the participants, however, specifically in relation to culture (Knoblauch, 2005). This aligned with our research questions as we looked to explore the culture and success factors of CoPs from the perspectives of *their* members.

3.2.1 Sampling

All nine CoPs in the parent study were initially chosen through purposive sampling (Conklin et al., 2011). They were chosen based on the fact that they were diverse and engaged in knowledge translation for older adults' care (Conklin et al., 2011). Two of the nine CoPs were purposively sampled for this sub-study after reading background material to aid in selection. This background material included the initial proposed protocol to study knowledge-to-action processes in the Seniors Health Knowledge Network (Conklin at al., 2011) as well as the findings from the analysis of a SHKN CoP aiming to improve oral care for older adults living in long term care or

hospital settings (Kothari, Boyko, Conklin, Stolee, & Sibbald, 2015). In addition to these articles (Conklin at al., 2011; Kothari, Boyko, Conklin, Stolee, & Sibbald, 2015), individual case study reports regarding all nine CoPs as well as cross-case reports from all three years of data collection were briefly looked over for CoP descriptions and information on types and amounts of data sources.

After reading the articles (Conklin at al., 2011; Kothari, Boyko, Conklin, Stolee, & Sibbald, 2015) in detail and looking over the descriptive sections of the individual and cross-case reports, the Firefly CoP (which worked on wound care issues) and the Mulberry CoP (which worked on complex care) were chosen for secondary analysis. Wound care, in the context of this study, refers to the management and treating of wounds in older adults, especially pressure ulcers (Gist, Tio-Matos, Falzgraf, Cameron, & Beebe, 2009). Wound care is an especially important area of interest within the realm of older adults' care because "chronic diseases that compromise skin integrity such as diabetes, peripheral vascular disease (venous hypertension, arterial insufficiency) are becoming increasingly common [and] skin breakdown with ulcer and chronic wound formation is a frequent consequence of these diseases" (Gist et al., 2009, p. 269). Complex care refers to care that does not fit within the traditional healthcare services due to the nature and complexity of patient needs such as multiple chronic conditions (Ritchie et al., 2016). Patients who require complex care may not be able to be placed within a specific department or area of care right away and therefore may experience difficulty navigating through the system (Ritchie et al., 2016). Complex care patients require integrated and interdisciplinary services involving professionals from various backgrounds with varying expertise (Ritchie et al., 2016). The goal of complex care resolution is for these professionals and interdisciplinary teams to work together in order to overcome gaps within the system and ultimately resolve individual patients' health challenges (Ritchie et al., 2016).

In terms of sample size, Creswell (2002) recommends studying one culture-sharing group for an ethnographic study. The Firefly and Mulberry CoPs can be considered part of the overall group of the SHKN communities of practice. Two individual CoPs were not only chosen as a result of the sampling strategies discussed below, but also for the purpose of adding rigor to the analysis. More CoPs could have been selected; however, the research team chose two CoPs in the interest of practicality and time. It is important to note that there can be different perceptions of culture

between CoPs or even between members of one CoP. Within the individual CoPs themselves, there may be different cultural values, attitudes and beliefs that are specific to them. This study focused on exploring the culture of two particular CoPs within the SHKN, as opposed to the entire SHKN. Keeping in line with a constructivist lens, we cannot claim that the cultures of the two CoPs in this study represent the overarching culture of SHKN.

In qualitative research, especially in relativist paradigms such as constructivism, there is a shift away from representativeness (Omona, 2013). "The goal is not to generalise to a population but obtain insights into a phenomenon, individuals, or events... and then the researcher purposefully selects individuals, groups, and settings that maximise understanding of the phenomenon" (Omona, 2013, p. 179). The Firefly and Mulberry CoPs were chosen through mixed purposeful sampling. Mixed purposeful sampling refers to using more than one purposeful sampling strategy together (Creswell, 2002; Miles & Huberman, 1994; Omana, 2013).

The Firefly and Mulberry CoPs were selected by combining criterion sampling and extreme case sampling. Criterion sampling refers to selecting individuals, groups, or settings that satisfy certain criteria chosen by the researcher(s) based on the nature of the study, research question(s) and methodology (Miles & Huberman, 1994; Omana, 2013). The main criteria that influenced sampling in this sub-study was the availability (or lack thereof) of diverse data for the CoPs. The Firefly CoP was selected because it yielded a large amount of various forms of primary data, including interview transcripts, interview field notes, field notes from attending two KT events as well as several CoP documents. Selecting the Firefly CoP aligned with the ethnographic methodology because ethnographies usually involve analyzing various types of data in order to explore a group/setting (Huot, 2014).

Since this study was conducted with a constructivist lens, an additional CoP (the Mulberry CoP) was chosen in order to look for diversity in the opinions, values, ideas and beliefs held by CoP members in general. Studying more than one CoP also allowed for a deeper understanding of their culture, assuming that in fact they have a culture. The purposeful sampling strategy used to select the second (Mulberry) CoP was extreme case sampling (Omana, 2013). Extreme case sampling involves selecting "an outlying case or one that possess one or more extreme characteristics... The method is to select extreme cases and then to compare them" (Omana,

2013, p. 180). The Mulberry CoP was chosen because it did not yield nearly as much primary data as the Firefly CoP. Initially, the analyst (i.e., the first author) was looking for both CoPs to be those that provided a lot of (rich) data. If a researcher is looking for rich information, it may lead to favouring certain participants, for example those who were articulate and met the researcher's assumptions. However, for a constructivist, the less articulate, or in the case of this study, the less "successful" case can also provide variability and diversity in exploring communities of practice (Williamson, 2006).

The aforementioned CoPs were also chosen due to the first author's interest in complex and wound care as well as the fact that these CoPs were analyzed most recently out of the total nine in the third and final year of data collection. The fact that these CoPs were two of the most-recently analyzed (and within the same year) is important because the data and resulting findings may be more relevant in terms of applicability by keeping the social/temporal context similar, as well as for potential publication purposes.

3.2.2 Data Collected

The research questions were explored by analyzing various forms of data collected from the two CoPs. A summary of the specific type and amount of data sources for the Firefly and Mulberry CoPs is demonstrated by the tables below:

	Interview transcripts	Field notes	Documents
Contexting interviews	4	4	0
Follow-up interviews	5	5	0
Concluding interviews	3	3	0
Final follow-up interviews	3	3	0
KTA event	0	2	0
CoP Documents	0	0	49
Total data sources	15	17	49

Table 1: Summary of data sources for the Firefly CoP (adapted from the individual Firefly CoP case report by Conklin and Chun (2015))

	Interview transcripts	Field notes	Documents
Contexting interviews	0	0	0
Follow-up interviews	0	0	0
Concluding interviews	2	0	0
Final follow-up interviews	0	0	0
KTA event	0	4	0
CoP Documents	0	0	6
Total data sources	2	4	6

Table 2: Summary of data sources for the Mulberry CoP (adapted from the individual Mulberry CoP case report by Elliott and Stolee (2015))

Including a diverse range of data in analysis coincides with conducting a constructivist ethnography (Williamson, 2006). Overall, the data included verbatim transcripts and audio from 30-60 minute semi-structured interviews with CoP members, observation and field notes regarding activities and documents produced and used by members of the CoPs. The interviews started by speaking to CoP leaders in order to learn about the specific CoP, its activities and the types of knowledge it was using. Saturation was reached by the fourth interview by the parent study team. The team also conducted purposive, follow-up interviews with knowledge users, knowledge brokers and CoP leaders in order to further explore the KT-related activities and behaviours. The interviewer made field notes after the interviews as well. Interview questions were formulated by the primary investigators on the research team and were derived from the concepts within the Promoting Action on Research Implementation in Health Sciences (PARIHS) framework (Kitson et al., 2008). The researchers chose the PARIHS framework as the basis for the study as it is used widely and focuses on facilitating KT initiatives. Member checking was carried out by giving transcripts back to the participants to review and suggest changes, and data were stored using the NVivo 9/10 software program. Observational notes were generated by a research assistant observing teleconferences. Following the teleconferences, the research assistant generated formal and detailed field notes regarding various KT aspects of

the CoP such as members' roles, types of knowledge used, and facilitation strategies used by the CoP. The research team also obtained relevant documents about the CoP from a liaison.

As mentioned previously, the research team generated individual case reports for all CoPs as well as cross-case reports for all three years of data collection. The analysis of individual cases and the cross-case analysis allowed the research team to propose preliminary answers to the research questions, and these answers were refined and analyzed as the case studies and cross-case analyses were completed (Conklin et al., 2011). Findings were reported as themes in relation to the research questions, both in the individual as well as the cross-case reports. Since this study concerning complex care and wound care employed a different methodology and focused on novel research questions, neither the individual nor the cross-case reports were analyzed as data. However, since these reports were read for the purpose of selecting CoPs, the first author included reflexive notes regarding their impact and influence on analysis (see Appendix B).

3.2.3 Data Analysis.

Ethnographic analyses are usually very flexible and open ended with little explicit guidance for analytic techniques in the literature (Williamson, 2006). There is no particular framework or approach (known to this research team) that provides guidance regarding analysis for a secondary ethnography. Therefore, we chose an approach (described in detail below) that seemed to be in line with the constructivist paradigm and best suited to answer the proposed research questions. Overall, we used a combination of coding techniques described by Spradley (1980) integrated with the two-cycle coding process outlined by Saldana (2009).

The analyst started by reading all the data from both CoPs three times without coding or formal analysis to become familiar with the data. It also gave her the opportunity to become aware of underlying assumptions regarding potential findings (refer to Memo 1 in Appendix C). We then used the approach described by Spradley (1980) to analyze data for ethnographies. The approach focuses on behaviour; however, in this study, behaviour *along with* perspective, values and beliefs were also looked at in relation to the research questions. In addition to Spradley (1980), the data analysis can also be considered as a two-cycle approach, with descriptive and values

coding comprising the first cycle, and pattern coding comprising the second cycle of analysis (refer to Figure 2 in Appendix A). Spradley's (1980) approach consists of three stages including domain analysis, taxonomic analysis and componential analysis. The two cycles and Spradley's (1980) approach were used concurrently, which amounted to three levels of iterative analysis.

During the domain analysis stage, the first author began with open coding to produce "raw", descriptive, initial codes, and then looked at different initial codes and how certain codes related to each other (Saldana, 2009; Spradley, 1980). During domain analysis, the first author began with an inductive approach by analyzing the verbatim transcripts, field notes and observational notes. This was carried out by first reading the transcripts/notes while simultaneously making initial notes and memos about key ideas (Williamson, 2008). The analyst continued domain analysis through descriptive and values coding until relationships between cultural values, beliefs and experiences emerged and formed categories (Spradley, 1980). This helped make connections between the participants' words and cultural meaning related to the research questions.

After domain analysis, Spradley (1980) suggests taxonomic analysis. Taxonomic analysis also involved descriptive coding as well as values coding (Saldana, 2009). During this stage, the analyst organized the cultural domains that emerged as a result of domain analysis. This was achieved by comparing and contrasting different codes and categories to find patterns (Spradley, 1980). Throughout the process of coding and determining general and specific categories, the analyst attempted to continually organize the categories by thinking deeply about the relationships, similarities and differences between them (Williamson, 2008). Taxonomic analysis helped form connections between the larger, encompassing ideas from the previous analytical stages. During the taxonomic analysis stage, it became apparent that some categories could be considered sub-categories of others.

The final stage of analysis was componential analysis (Spradley, 1980). According to Spradley (1980), componential analysis is the “systematic search for attributes (components of meaning) associated with cultural categories” (p.131). Within componential analysis, the first author used her interpretation to impose patterns upon the data by utilizing pattern coding, which refers to deriving codes that are "explanatory or inferential [and] identify an emergent theme, configuration, or explanation [by grouping various initial codes] into ... meaningful and

parsimonious unit[s] of analysis... [such as] themes, or constructs" (Miles & Huberman, 1994, p. 69). Taking into account the constructivist position of the researchers, we did not seek out a theoretical framework to apply to the results. The results were reported as overarching themes with subthemes. A more detailed explanation of the analytical approach can be found in Memo 3 under Appendix C. The following figure summarizes the analytical process:

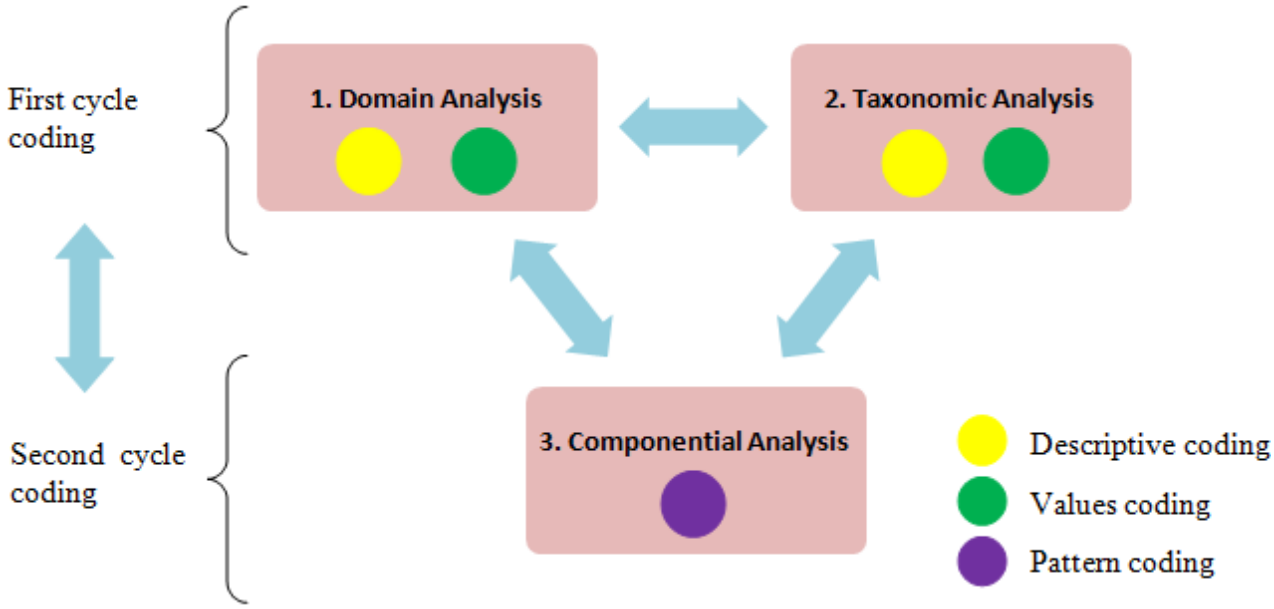

Figure 1: Summary of Data Analysis Process. The analytical process was mainly based on Spradley's (1980) approach. However, within Spradley's three-stage process, we utilized first and second cycle coding as well. Descriptive coding and values coding were used in the domain and taxonomic analysis and composed the first cycle. Pattern coding was used in componential analysis and composed the second cycle. The multidirectional arrows indicate the fact that analysis was not a linear process, but rather iterative and dynamic with many instances of re-visiting data sources and the different analytical stages.

The NVivo Pro 11 software program was used to organize codes, categories, relationships and themes during analysis. The program was not use to perform the coding itself. The data from the Firefly CoP was analyzed first before moving on to analysis for the Mulberry CoP. Within each CoP, especially the Firefly CoP, the transcripts, field notes and observation notes were first analyzed in a chronological order. Although the data analysis process is described in cycles and stages, it was not linear but rather iterative as many data sources were re-visited several times,

regardless of the time of collection, as relationships, categories and themes started to emerge. This also meant that the process of analysis did not really unfold as a "three-stage" process described above. These stages were merely used as guides to organize thoughts and interpretations and often overlapped and intertwined as the analyst went back and forth between data during coding.

3.3 Self-Reflexivity and Memo Writing

As mentioned previously, one of the quality criteria for qualitative research is sincerity. According to Tracy (2010), sincerity in qualitative research "can be achieved through self-reflexivity, vulnerability, honesty, transparency, and data auditing" (p. 841). Sincere "research is marked by honesty and transparency about the first author’s biases, goals, and foibles as well as about how these played a role in the methods, joys, and mistakes of the research" (Tracy, 2010, p. 841). Keeping reflexive notes can help accomplish sincerity in research. Through keeping reflexive notes, a secondary qualitative analyst can be clear about these issues throughout the research process from determining the analytical technique(s) to publication. If a researcher engages in "explicit, self-aware analysis of their own role" in a project, it offers a basis for evaluating their research (Finlay, 2002, p. 531).

Keeping in line with the constructivist paradigm, the first author kept extensive and detailed reflexive notes throughout the course of this study. The first author started keeping reflexive notes as soon as she knew about the potential of a project regarding communities of practice, before even formally starting the project. The reflexive notes consisted primarily of the first author's point of view on secondary qualitative research and the process of deciding on conducting such a study. These reflexive notes were both in written and audio form. For the most part, the analyst wrote down her thoughts whenever she felt the need. However, at some instances, the lack of a computer (for example, while travelling on a bus) prompted the analyst to record her reflexive notes on a recording device. These audio-recordings were later formatted into written notes. All reflexive notes can be found in Appendix B.

Over the course of this study, the reflexive notes seemed to transition into analytic memos as the focus shifted from writing the research proposal to actually analyzing the data. Analytic memos

are supposed to give the researcher an opportunity to express, to themselves, their thoughts and lessons during and after data analysis (Center for Evaluation and Research, n.d.). Analytic memos can be written whenever and as often as the researcher feels necessary. They may also range in length from a few sentences to several pages depending on the amount of detail required to resolve ideas (Center for Evaluation and Research, n.d.). The content of analytic memos should focus on results and finding that both *are* and *are not* apparent in the data. The researcher can use memos to summarize findings or reflect on the results of analysis (Center for Evaluation and Research, n.d.). If the opportunity is present, analytic memos can help guide the collection of additional data based on results from already collected data (Center for Evaluation and Research, n.d.). Ultimately, memos can help in writing the findings and results sections of a thesis, research report or article (Center for Evaluation and Research, n.d.).

For the first author, the difference between reflexive notes and analytic memos was the fact that the reflexive notes focused more on her personal thoughts and feelings about the secondary analysis and the journey towards the decision to conduct a secondary study regarding CoPs. On the other hand, the analytic memos were used to document thoughts and lessons learned during and after data analysis. Since a large portion of data consisted of interview transcripts, the analyst wrote analytic memos after analyzing each group of interview transcripts from the Firefly CoP. For example, a memo was written after analyzing all four contexting interviews, then after analyzing the field notes from a CoP event and again after analyzing all follow-up interview transcripts. Since there was a significantly lower amount of data concerning the Mulberry CoP, one analytic memo was written during and after analysis. All analytic memos can be found in Appendix C.

Chapter 4

4 Results and Findings

This chapter begins with an introduction of the members of the Firefly and Mulberry CoPs whose interviews partially served as data for this study. Following the description of participants, the major emerging themes in this study will be presented with illustrative quotes that have been edited for readability (e.g., phrases like “you know” and "I mean" have been removed). The major themes include: 1) Hope and Desire to Cause Real, Effective Change, 2) Appreciation for Bringing Together Diverse People and Experiences, 3) Aspiring to Work Together as a Harmonious Team, 4) Striving for Strong Work Ethic and Good Practices to Achieve Efficiency and Productivity and 5) Tensions, Worries and Uncertainty.

4.1 CoP Members and Initiatives

Before presenting the results, it is important to describe the participants of this study and the goals they were trying to achieve with their respective CoPs. Through providing some additional context regarding participants' roles and goals, we aim to allow for a better understanding of the attitudes, values and beliefs held by the CoP members.

4.1.1 CoP Initiatives Overview

The primary goal of the Firefly CoP was to improve the attention to skin care for older adults while they transitioned between healthcare settings. Ann[2], a co-lead of the Firefly CoP described the CoP's purpose as follows:

> ... we really want to focus on pressure ulcer prevention. We thought that was one key thing that applies to all sectors... we realized there really is a big gap in communication... [so, when a patient] gets sent to the emergency room... for pneumonia, the entire focus is on their pneumonia and you totally forget about their pressure... As soon as they leave that organization, you're starting from scratch again and it takes a few days for people to get things set in motion… So rather than depending on the organization to fill out the paperwork and relying on the receiving organization to accept it and rake through… we

[2] The identities of participants have been changed to ensure confidentiality.

> decided it would be a really good idea if we could do it where... the patient, or the family have some kind of control, first of all to make sure the information gets passed on, but then also that the information is kept up to date, and that's when we started thinking about developing this passport tool. (Ann, Firefly CoP)

The primary goal for the Mulberry CoP was to develop a framework to improve healthcare service delivery for responsive older adults with difficult behaviours. One of the Mulberry CoP documents provided an overview for its initiative and described its goal as follows:

> This... initiative evolved out of [a larger network], which discovered that several LHINs (Local Health Integration Networks) were implementing processes for handling situations where persons with responsive behaviours had complex needs that went beyond the ability of a particular group... or service provider to resolve. These processes typically involve bringing together various local experts in a timely manner to develop a solution together. [The larger network] looked at these processes and identified commonalities, and then proposed a set of guidelines ... to be considered in the implementation of any similar local processes. The new leadership group for [the larger network]... decided to look at the implementation of these guidelines locally through the sharing of an example of a local... process at each of their monthly meetings...

In summary, the Mulberry CoP was supporting a process for improved care for older adults with difficult behaviours. Their goal was to develop a framework for managing cases that could not be resolved by practitioners or a particular intervention. The CoP aimed to use the Critical Incident Analysis Framework along with examples of local complex care resolution processes to guide the development of the framework.

4.1.2 Study Participants

Nine Firefly CoP participants were interviewed during data collection for the parent study. They held diverse roles and responsibilities, both within the CoP as well as on a larger scale within wound care health delivery. For the Mulberry CoP, there were only two participants who were interviewed (their roles were not specified). See Tables 3 and 4 (below) for details.

Pseudonym in this sub-study	Occupation/ Role in Firefly CoP	Notes
Patrick	Knowledge broker	
Ann	Nursing background	Co-lead of CoP
Olivia	Co-chair at [a healthcare organization]	Co-lead of CoP
Emily	SHKN's technology and administrative manager	Had limited interaction with clinicians and frontline workers

Mary	Former nurse in First Nations Communities; an educator and works in community engagement and liaison at [a healthcare organization]	Not a CoP member but participated in a webinar; found passport relevant to her work
Jennifer	Advanced Practice Consultant for Wound Ostomy	Did not participate in webinars
Wendy	Works in knowledge translation at [a healthcare organization]	Only involved in steering committee at the beginning
Sarah	Personal Support Supervisor at [a healthcare organization]	Did not attend webinar; has previous experience with wound care
Ashley	Integrated wound care program lead with [a healthcare organization]	non-clinical wound specialist and speaks more from an administrative perspective
Haley	N/A	Member of parent study team; interviewer and author of field notes

Table 3: Pseudonyms and Attributes for the Firefly CoP Participants

Pseudonym in this sub-study	Occupation/Role in Mulberry CoP	Notes
Brian	Clinician	Only involved in the meeting from June 13, 2013
Stephanie	Employee of [an organization concerning older adults' healthcare]; helps operationalize a network on the ground across the various sectors; appointed regional coordinator by the LHIN	
Jonathon	Holds leadership role in behavioural support services for the Southeast LHIN, and hirer by [a healthcare organization] to implement and manage the program	
Sam	None provided in parent study notes	Only shows up as attendee in the field note from June 6, 2013

Alex	None provided in parent study notes	Only shows up as attendee in the field note from June 6, 2013
Chris	None provided in parent study notes	Only shows up as attendee in the field note from June 6, 2013
Rachel	N/A	Member of parent study team; interviewer and author of field notes

Table 4: Pseudonyms and Attributes for the Mulberry CoP Participants

4.2 Emergent Themes

Five major themes emerged from the data: 1) Hope and Desire to Cause Real, Effective Change, 2) Appreciation for Bringing Together Diverse People and Experiences, 3) Aspiring to Work Together as a Harmonious Team, 4) Striving for Strong Work Ethic and Good Practices to Achieve Efficiency and Productivity and 5) Tensions, Worries and Uncertainty.

The theme, Appreciation for Bringing Together Diverse People and Experiences, was not apparent in the Mulberry CoP data. All of the other four themes were apparent in both communities of practice. The Firefly CoP data also contributed a significantly higher number of codes and categories to the aforementioned themes as compared to the Mulberry CoP.

4.2.1 Hope and Desire to Cause Real, Effective Change

The data for both CoPs showed that there existed a shared culture in which members cared about the cause of their CoP and found value in their respective initiatives. There was a culture of personal investment in the initiatives and a strong desire to be a part of bringing change through the CoP initiative. The categories that composed this theme included Passion for the Cause, Desire to Make a Difference, Desire for Improvement (of self and the system), (Importance and Lack of) Commitment and Engagement to Cause, Finding Encouragement and Motivation in Incremental Successes, and Fear of Futile Efforts.

There were several instances where participants' answers to questions showed their **passion for the CoP's cause and their desire to make a difference** within the realm of skin care for older adults. For example, during her interview, Sarah (a Personal Support Supervisor who became interested in the My Skin Health Passport due to previous work in wound care) said, "I think it is

a great idea, yup. I think it is really important. It is different and I don't know why nobody thought of this a long time ago". In her final interview, Ann, who was a co-lead for the Firefly CoP and possessed a nursing background, said,

> I did enjoy the process and I was glad to be involved in that, and... I am really happy with the product that we ended up with at the end of it... I'm glad I went through the experience. I am glad I had done it. I would do it again. (Ann, Firefly CoP, Co-lead)

Another CoP member, Mary (a former nurse in First Nations Communities and also an educator who worked in community engagement) believed that the CoP initiative is a useful tool. Mary's thoughts about the potential of the My Skin Health Passport demonstrate her hope to influence positive change in the care of older adults who may require extra attentive skin care. She expressed her belief in the initiative as follows:

> I think any organization if they're receiving a client or a patient, would be more than happy to receive a document like this where it actually specifies the needs for that client as a starting point for them for their assessment. Especially, like I say, for those clients that… maybe have dementia or are less able to communicate verbally or language barriers, that kind of thing. I think this is really important. (Mary, Firefly CoP)

The field notes written by Haley, the interviewer (who was part of the parent study team) also reiterated the participants' passion for the initiative. For example, she noted Sarah's passion for using the passport in order to educate her team of Personal Support Workers and ultimately improve the quality of life for their patients:

> [Sarah] is a Personal Support Supervisor at [healthcare organization]. In her current position, she does not deal with many clients with wound issues, but the topic is important to her as she has previous experience working in the field of wound care... [Sarah] is passionate about her work, and really seems to see the value in the Passport tool and the benefits it could bring to her organization. She listed many ways in which the tool and wound care knowledge in general could be disseminated within her team, and felt that the PSWs with whom she works would be very receptive to this tool and new information. (Haley, Field Notes)

During another interview with Olivia, another CoP co-lead, she expressed her belief in the CoP initiative by stating that she thought it was a "great idea" and that the My Skin Health Passport was a "truly valuable" product of the CoP. Olivia further demonstrated her belief in the initiative by stating, "Ultimately, I guess, in 5 years, what I would like to see is that, when I'm being wheeled in as the senior going in there, that somebody says to me, 'do you have your Skin

Health Passport?' and I do." (Olivia, Firefly CoP, Co-lead). The field notes written by Haley after Olivia's interview reiterate Olivia's belief in her work and the CoP initiative as she noted that Olivia seemed to be continually thinking of ways to disseminate and encourage the use of the CoP initiative. For Haley, the second interview with Olivia "really reinforced how passionate she [was] about the topic" and "how strongly she believes that the Passport tool should be integrated by health services in Ontario" (Haley, Field Notes).

The desire to influence change in service quality based on confidence in the CoP initiative was apparent in the Mulberry CoP as well. Members thought that they could "see [the framework] enriching the complex care resolution process" (Brian, Mulberry CoP, clinician). Jonathon, another member of the Mulberry CoP also demonstrated belief in the CoP's initiative. When questioned about whether he thought the framework had potential to improve care, his answer (below) showed his confidence in the initiative's potential:

> Yes, I do. Because I know... the people who are in hospital... who have the responsive behaviours, they are not able to get into long term care or other types of living arrangements... So we see this as an opportunity to come forward and talk about the issues, develop some pretty complex transition plans and collaborative care plans that will provide a seamless transition for the individual and their family... it has a lot of merit and I think it speaks to our role in the Southeast for ongoing collaboration. (Jonathon, Mulberry CoP)

There were also instances where participants showed interest in the CoP initiative based on personal experiences, especially in relation to older family members. For example, when explaining the value of the My Skin health Passport, Emily, SHKN's technology and administrative manager said:

> ... I think it's just a good thing to know, especially if your grandparents and your parents are aging and my grandfather is actually... wheelchair-bound right now in a nursing home with dementia... So that's something that I might even recommend to my grandparents and to their care team... to have a look... and see if it would be useful for them and then something just to keep in mind as my parents start aging too. (Emily, Firefly CoP)

The members' passion was fueled by a **desire to cause positive change**. Part of the care **improvement** that the CoP members wanted to bring about concerned involving patients in their own care. The CoP members wanted to change the fact that patients are not always involved (enough) in their own healthcare. They were not necessarily able to involve patients or families

as part of the CoP; however, the Firefly CoP still seemed to acknowledge patients as important and responsible stakeholders. For example, when asked about the potential of the initiative to bring about change, Patrick, the knowledge broker for the Firefly CoP stated that the passport looked at wound care from a new perspective because it focused on prevention rather than treatment. He also said that this passport possessed originality because it would be carried by the patients, engaging them in their own care. Patrick's comments demonstrate his awareness that the current healthcare system often fails to acknowledge the importance of patients as stakeholders in their own health and care. Patrick's point of view regarding changing this notion was reiterated by other CoP members. For example, Ashley, an integrated wound care program lead with [a healthcare organization] said:

> I think what's changing is that here... we talk about collaborations, but if we focus on the patient and this is an example where the tool is patient-centric. If we focus on the patient, then a tool like this can be very useful to understand that healthcare needs to be looked at from a continuum perspective and from the patient's journey perspective rather than any one sector. So, does this represent that change? I think so, because it is patient-centric and it's not being endorsed by any one sector, at least that I'm aware of. (Ashley, Firefly CoP)

The Firefly CoP members also demonstrated their belief in the initiative through striving for **commitment and engagement** in the CoP's efforts. For example, members expressed interest in continuing to work on the CoP initiative even after its end and sometimes even after the members had officially left the CoP. For example, in her final interview, when asked about her future plans in relation to the passport, Olivia said,

> ... the incentive for us to do this is because we are nurses and because we're interested and keen... health care providers are passionate about making things better and they'll work at it, whether they get paid to do it or not... Ann and I are committed to continuing to work on this… so, in our own sort of way, we're going to do this. (Olivia, Firefly CoP)

Haley's field notes written after the final interview with Ann reiterated Olivia's thoughts as she noted that Ann planned to continue dissemination efforts with Olivia through social media (e.g., YouTube) and publications in order to reach leaders/decision makers in relevant organizations. Over the course of all her interviews, Olivia also expressed her hope for success of the passport (specifically its uptake by patients and healthcare organizations) as follows:

> I'm optimistic that if we get the message out to the community, particularly to long-term care and home care to begin using the tool and for hospitals, particularly emergency departments, to know that this is a tool that people are bringing in. It's kind of like advanced directives... And now in hospitals it's a standard question, "Do you have advanced directives?" So I'm hoping this is where we'll end up is, "Do you have your passport? Do you have your passport for skin health?"... It would be nice within 5 years to see that every patient that goes into the hospital, gets asked if they have their passport... Like, how good would that be? (Olivia, Firefly CoP)

Although the CoP members planned on continuing work on the CoP initiative after the CoP's end, it is unclear how much success they had in this regard. To our knowledge, there were not many dissemination efforts after the Firefly CoP had ended. Perhaps this was due to the participants trying to show themselves as committed members through expressing these aspirations, when in reality, working on the passport after the CoP's end was probably unlikely. Regardless, the participants' words showed they aspired to be committed members of the CoP in order to bring about change in wound care for older adults.

The CoP participants expressed such investment in the CoP initiative and had so much hope for success that there was almost **a sense of fear of their work going unnoticed**. This can be considered a desire to have the initiative successfully disseminated, since knowledge translation projects in healthcare usually involve a dissemination stage for an initiative/product. However, the way participants talked about disseminating the passport and wanting it to be recognized showed hopeful thinking that aspired for success. Members explicitly expressed the fact that they would be very disappointed if their work and efforts did not get disseminated successfully and got lost in the literature. Olivia and Ann were exceptionally articulate in expressing their fears of the passport getting lost and not getting implemented. Ann was concerned that the initiative would "wash away" after the CoP ended. Olivia noted that her "biggest fear" is that this tool is just something that will be introduced, and then forgotten:

> ... the objective of the CoP was to create, to look at preventing skin breakdown for seniors and we felt that with the passport for skin health we accomplished that. So part of what I wanted to do... was promote the fact that this is something that has been accomplished and it's done... the thing I want to see is... it's not something I find in a box 10 years from now and go, "oh, that was a really good thing that we did… and it's gone nowhere"... and unfortunately, I've seen enough of those things in my life to say, I would prefer not to see that happening with this… I don't want to see this be another thing that just… "it was a really great idea" and then it's done and it disappears. That would be my one fear is that that's what's going to happen. (Olivia, Firefly CoP)

The fact that participants were hopeful for success and expressed fear of failure may also be indicative of shortcomings in the project. Perhaps failure to disseminate and facilitate the uptake of the passport was a strong possibility for the members. The fear of the passport not being recognized was also interpreted by a team member as a worry that participants' reputations may suffer if they were perceived as having been unsuccessful.

In relation to the fear of their work going unnoticed, the CoP participants found **encouragement in incremental successes** related to the uptake of the passport. For example, in her very first interview, Ann seemed excited to share a story that involved a couple of her colleagues coming across the initiative unexpectedly. Two of her university students who were working on a different project happened to come across the My Skin Health Passport, which was encouraging for Ann. During an interview with Patrick, he also spoke of a small success story regarding positive feedback about the CoP initiative at a conference presentation that provided encouragement for the CoP members, especially Olivia. Further conversation with Patrick about the CoP's success stories re-iterated the members finding encouragement in stakeholders' interest in their work:

> There were a couple of supervisors who said they were interested... and wanted to give [the passport] a try... and we had our own lead in terms of wound care at [healthcare organization]. [Jennifer], who is interested in it as well, as a tool that she would like to see how we'd use it. So I think that success story was more about actually putting it out there and having positive feedback in terms of saying they were interested in it, and they would like to consider how they were going to use it. (Patrick, Firefly CoP)

Finding encouragement in mere stakeholders' interest in the CoP initiative, again, demonstrates the **participants' hope for success**. Although the CoP might not have achieved behavioural change, the fact that stakeholders were interested in the initiative meant that they raised awareness about issues in wound care for older adults, which was a point of encouragement.

Therefore, there were several instances when the CoP members spoke about the desire they had for the success of their initiative. There seemed to be a common culture of hope and for success that was apparent in interviews will all members of the Firefly CoP, especially the leaders (Olivia and Ann). Members found encouragement in stakeholders being interested in the passport and planning on using it in practice. The lead author's interpretation is that this hope, desire to influence change and fear of futile CoP efforts signifies the members' aspirations to

make a difference with their work. Together, these ideas came together to form one of the most prominent themes: Hope and Desire to Cause Real, Effective Change.

4.2.2 Appreciation for Bringing Together Diverse People and Experiences

Another theme that emerged from the Firefly CoP concerns diversity in terms of different professionals coming together to contribute varying experiences and perspectives while working on a CoP initiative. In addition to professional diversity, the CoP members expressed the value of involving and accounting for patients and their families as important stakeholders in the initiative, although this was not translated into action. The CoP members demonstrated the presence and importance of diversity by displaying collaboration (mostly at the start of the initiative), placing high value on members' input and feedback and drawing on diverse experiences as motivation and for carrying out CoP efforts. Diversity as a theme was only observed and interpreted through the data for the Firefly CoP. There was no data from the Mulberry CoP that contributed to this theme. This distinction between the culture of the two CoPs is explored further in Chapter 5 (the discussion).

The Firefly CoP was composed of individuals that came from **diverse professional backgrounds** in relation to wound care for older adults. "Members of the Community of Practice [were] formal and informal caregivers including nurses, rehabilitation therapists, personal support workers, wound care experts, researchers, policy makers, educators, and librarians" (Firefly CoP Document). The value that the CoP placed on diversity was clear even from the beginning stages of the CoP. For example, planning documents that were written before embarking on the CoP initiative stated that one of the aims of the CoP was to "establish [an] Advisory Committee that represents multidiscipline and health care across all sectors" (CoP Work Plan Document). Although this advisory committee did not remain active until the end of the CoP, they helped determine the direction for the CoP at the beginning. Furthermore, during her first interview, when Ann was asked about the CoP membership, she explained:

> I think the membership itself is quite large... It's made up of a number of different people. Some of them being what you would consider like leaders in the field and then others being nurses, being patient care attendants... we all came from completely different

> sectors... very initially as the group, we had somebody who worked in acute care, I worked in complex care, someone worked in homecare, someone worked in long term care, somebody was like at the political level.. we're just from different backgrounds. (Ann, Firefly CoP)

In addition to the membership itself, the CoP also tried to target a diverse group of individuals for dissemination purposes. For example, for both webinars that introduced the passport to the extended wound care community, the CoP members were able to reach different individuals. Before the first webinar, when Patrick was questioned about the attendees, he mentioned that the CoP tried to bring together "a very diverse group of people" who belonged to different sectors and organizations. Once the webinars took place, it was more apparent that the CoP members not only valued a diverse audience, but were also successful in achieving this goal as explained in the field notes written by Haley. In both webinars, the CoP leads conducted polls asking participants about their professional backgrounds. Although there were no patients, family members or caregivers present at the webinars, the rest of the attendees "came from all sectors of the health care continuum". The results indicated that although most of the webinar attendees come from long term care, there were also people from acute care, research, academia and education.

The Firefly CoP also demonstrated that they valued **collaborating with various professionals and organizations** to disseminate the passport. Within the **Professional Collaboration** category, some common ideas that came through as factors that participants deemed necessary for success were using personal and professional connections to further the reach of the initiative as well as acknowledging and relying on experts in the field. For example, they tried to reach different organizations that were influential in the wound care realm to further the influence of the passport during the dissemination efforts. During her contexting interview, Wendy, a CoP member who was part of the steering committee explained that the CoP connected with the Ontario Wound Care Interest Group, Health Quality Ontario and the Registered Nurses Association of Ontario (RNAO) in its early stages.

Participants also valued **making, maintaining, and utilizing professional connections** to disseminate the passport. Members were aware that achieving success with the CoP initiative "requires time, expertise and connections across health care" (CoP Work Plan document). They sought collaborative opportunities "to develop relationships between CoP and professional

organizations to disseminate knowledge and increase membership" (Firefly CoP document). For example, a CoP document describing its progress explained that

> The Firefly CoP ha[d] established a relationship with a number of key wound experts including the Registered Nurses Association of Ontario (RNAO) Wound Interest Group, the Toronto Health Economics and Technology Assessment (THETA) Collaborative, the Ontario Health Quality Council (OHQC) and the Canadian Association of Wound Care (CAWC)... In addition, the CoP [was] strategically networking with members of the wound care community to foster knowledge of pressure ulcer prevention, current best practice recommendations and successful implementation and sustainability strategies. (Firefly CoP document)

The participants reiterated the fact that the CoP and its members constantly looked for opportunities to use professional connections to help achieve the CoP's goals (in this case, the dissemination of the passport). Olivia and Ann were both well connected within the wound care community and tried to use these connections for the purpose of the CoP (Haley's field note after Olivia's contexting interview). The following quote further demonstrates this idea:

> Sometimes we met leaders at things like the OntWIG group... one of the people that we met, for example, was a consultant, a wound care consultant that was hired occasionally by some of these new – these smaller nursing homes to come in and help them with their wounds, and so again, we sort of used any connections that we could make to try and get into that sector a bit more. (Wendy, Firefly CoP)

Not only did participants consider diverse collaboration a success factor, but they also expressed the notion that collaborating with the *right* individuals and organizations was important. Ann explained that the CoP discussed collaborating with RNAO and the Canadian Association of Wound Care (CAWC) because "they're huge organizations and that way [the passport] can continue to... evolve and move along..." (Ann, Firefly CoP). Olivia also explained that as a CoP, they wanted to collaborate with organizations that had international connections as well and therefore were "the place to go". Although participants expressed the importance of diverse collaborations, it was unclear whether they were able to act on these intentions. Still, the participants' perspectives signified the value of diverse collaboration as a CoP success factor.

In addition to the individuals and organizations themselves, the **experiences that the CoP members drew on for motivation and during working on the initiative also showed diversity**. These experiences included both professional ones (such as those shared by experts in the field of wound care) as well as personal experiences that helped members realize the value in

the CoP initiative. Relying on experts' experiences was a success factor for the Firefly CoP and at the start of the passport initiative, they strived to include expert opinion and experience through a steering committee (although just at the very beginning) that guided the CoP to choose its goal. The co-leads perceived the initiative to be a success in that they developed and disseminated the passport tool. There was no evidence reported of concrete changes to frontline practice. Still, it seemed that some conversations had begun, and it was possible that the initiative might continue to evolve. At the time of data collection, however, it was unclear whether this evolution had begun. Therefore, the members' perspectives were interpreted as appreciation for incorporating diverse experiences in a successful initiative. Another CoP document indicated that the CoP aimed to "engage and encourage the active participation of members, from [their] own CoP or others, depending on the project at hand. Specialists (external to CoPs) [could] also be invited to participate in specific endeavours or at particular points (e.g., fact-finding)... " (Firefly CoP Document).

As mentioned before, the CoP members came from different professional backgrounds within wound care. The group "had somebody [who] worked in acute care, ... complex care, someone worked in homecare, someone [who] worked in long term care, somebody [who] was like at the political level" (Ann, Firefly CoP), along with several other individuals (refer to Tables 3 and 4). The fact that the CoP was made up of various professionals meant that the experiences they brought to the table were also diverse. The CoP tried to incorporate and **bring together these diverse experiences by requesting and tending to feedback and input**. They wanted to make sure that the change they help create was beneficial and aimed to "ensure evaluation feedback is used to inform future activities" (Firefly CoP Work Plan Document). Therefore, there was a lot of focus on improving the passport and evaluating it based on feedback and input from not only the core CoP members, but also those who had an indirect link to the CoP through attending a webinar or coming across the passport elsewhere. Although some professional tensions arose (discussed further in Section 4.2.5), the Firefly CoP members, especially the co-leads, aspired to create an open and interactive environment that was conducive to discussion; they also welcomed feedback from extended CoP members and users of the My Skin Health Passport.

A planning document for the Firefly CoP stated from the beginning that it was important to "engage wound care community and gather input/guidance on future CoP areas of focus, gaps

and opportunities " and "ask for feedback from others on how to move forward and continue to ensure success". Before embarking on the initiative, the CoP planned that the CoP would be in "regular contact with its membership" and would gather input through surveys, "webinars, bulletins, reading lists, developed tools etc." for evaluation purposes (Firefly CoP Preparatory Document). During her final interview, Ann stressed the importance of gaining and incorporating input from the diverse community that was part of the CoP in the form of extended members:

> ... our approach in all of this is just to keep it very informal and create conversation and encourage conversation and I think that that's..., one of the key things is having people being able to say "well, it's going to work" or "it's not going work" or "what about this?" and… and I think it just helps the dialogue … I mean both the knowledge transfer as well as taking it to the next step of beyond the knowledge but into the practice change. So... that's the main approach that we use, is really encouraging – giving them the tool... but then encouraging the conversation that goes with it. (Ann, Firefly CoP)

Similarly, during the first webinar,

> "[Olivia] stresse[d] the importance of gathering feedback and input from the participants... [She] stresse[d] the importance of feedback on availability, access, how easy [the passport] is to use in reality, etc. "We really want to know what you, what your patients, what the community thinks."... She identifie[d] this process as critical, and invite[d] participants to share their thoughts with [Patrick] as their contact person... [Ann was] also very keen on hearing feedback. (Haley's field notes after first webinar)

The field notes written by Haley after the webinar reiterated the CoP members valuing diverse input and feedback:

> One thing that really jumped out at me was how important the notion of feedback was to the presenters. It was a recurring concept throughout the whole webinar – the idea that any feedback that participants could share about the accessibility or the usability of the tool was welcome and would help to improve the tool and make it more effective for patients... The presenters were also very receptive to feedback and encouraged participants to share their thoughts and ideas on how to improve the tool. (Haley's field notes from first webinar)

Similarly, after the second webinar, Haley noticed that

> The team of presenters worked together and did the best they could to create an environment that was open and informal, and encouraged participants throughout the session to provide comments or ask questions. They engaged the webinar participants at the very beginning by inviting them to answer a poll question about the sectors in which they work, to get a better idea of their audience. The presenters specifically scheduled time during the webinar for questions and comments, and invited participants to join in

> on the discussion. I felt that they were very effective presenters/facilitators and did everything they could to facilitate a discussion... There were a number of discussions about how to best approach the issue: they understood that there was a communication breakdown as a patient moves from one facility to another, and they understood that in many ways, patients manage their own care. They put the Passport together to address these factors, held a few webinars and discussions like this one with the rest of the CoP to get some feedback, and refined the tool using the feedback. (Haley's field notes from second webinar)

Not only did the Firefly CoP co-leads value feedback and input from members, but they also showed responsiveness to this input by making improvements to the initiative based on feedback received through webinars or other forms of communication such as emails or conversation. In his contexting interview, Patrick explained that the CoP had conducted a survey to "gather the CoP members' perceptions of what the passport tool should look like". They developed the passport based on this input and shared it during webinars to allow "people with different forms of practice" to "test it out" and provide further feedback. Similarly, during the second webinar, "the presenters reiterated the fact that the different sections of the Passport were developed based on the literature to ensure that the information on the Passport would be relevant, and refined through feedback from people working in the field" (Haley's field notes after second webinar).

The last aspect of diversity that came through in the data was regarding a sense of not only collaborating with diverse professionals, but also **aiming to involve patients and their families** in the care process. Members showed concern for patients' health and well being, which translated into holding patients' and their families' involvement in implementing the initiative as an important success factor. It was apparent that the CoP members "wanted something...that's going to benefit the patient" (Ann, Firefly CoP). "The knowledge used to develop the tool came from a combination of research and patient experience"... The knowledge used to develop the tool was explicit (derived through literature) and tacit (as the tool was shaped through the experiences of patients and their families)" (Haley's field note from first webinar).

For Ashley, the involvement of patients as stakeholders acted as motivation for her to contribute to the CoP initiative. Similarly, during her very first interview, Olivia mentioned that although the My Skin Health Passport would be beneficial to patients, it was up to them and their caregivers to make use of the product. However, Olivia did stress the importance of making the

passport easy to access and use. Overall, "she seemed to place an emphasis on the importance of considering patient perspectives in the development of an effective tool" (Haley's field notes).

The webinars also signified the members' appreciation of incorporating patients and their perspectives to successfully achieve the CoP's goals. In the first webinar, when questioned about whether the CoP had tested the passport with patients and families, Olivia explained that they conducted a small focus group with a some patients and their families, "who had made suggestions that [were] incorporated into the tool... She talk[ed] about the importance of sitting down with the patient, and getting the patient's perspective" (Haley's field note from first webinar). She stressed the importance of involving "all knowledge users in the process of implementing the Passport into practice.... by raising awareness of the importance of the tool and encouraging [patients] to use it and provide feedback" (Haley's field notes from second webinar). According to Olivia, "when consumers are involved in the process... the message is far more powerful". Although the Firefly CoP co-leads stressed the importance of patient involvement, the only time it was mentioned to have taken place was when the focus group was mentioned. However, this focus group was mentioned only once and by one person during a webinar, and there was no evidence of its details regarding questions, number of patients involved etc. anywhere else in the data set. Therefore, the mere mention of this focus group could not be interpreted as the actual involvement of patients and families. Regardless, it was clear that the CoP members aspired to involve patients and families in the CoP initiative as they believed it would be vital for success.

Therefore, the Firefly CoP co-leads showed an appreciation for the importance of diversity through professional collaboration with different individuals and organizations. They also aspired to incorporate members' input along with the patients' perspectives. Although it was unclear whether this appreciation translated into action, the CoP members showed that they valued diverse experiences and perspectives coming together to achieve success.

4.2.3 Aspiring to Work Together as a Harmonious Team

A theme that was readily apparent in both the Firefly and Mulberry CoPs was Aspiring to Work Together as a Harmonious Team. Several participants expressed the importance of working

together, and helping each other out, to successfully achieve the goals set by the CoP. Some of the main ideas that composed this theme concerned proper communication, teamwork, striving for a positive work environment, engaging in discussions and the importance of team members fulfilling their roles (such as facilitation and leadership). Although the CoP members aspired for harmony, there were challenges that hindered achieving a harmonious team environment in practice.

The CoP members aspired for **proper communication** as an important aspect of the group dynamic. Based on the participants' interviews and the field notes written by the primary data collectors, the first author interpreted proper communication as open communication channels between CoP members about roles, responsibilities and conflict resolution. Proper communication between the CoPs and external members/organizations was interpreted as productive dialogue that helped further the CoP's goal. The CoP demonstrated good communication, however, mostly at the beginning of the initiative. For example, Patrick (the knowledge broker and facilitator) explained that the community of practice in the early stages of the passport initiative was quite independent and "had a plan in place of what they wanted to do" (Patrick, Firefly CoP).

Although there was some evidence of good communication amongst the CoP members in terms of determining the CoP goal at the beginning, the participants cited a lack of communication as a major barrier to success. Therefore, the participants' perspectives signify communication as vital for achieving harmony and success as a team. For example, Olivia stated: "I think one of the issues through my perspective was that there wasn’t very good communication about the CoP in the first place. I’m a wound care person and I had no idea that this was out there" (Olivia, Firefly CoP). Similarly, in regards to the webinar, Ann explained that there were not many attendees, which might have been a result of failing to communicate with extended members about the webinar.

Although it was not always evident in their actions, participants not only aspired for proper communication within the CoP, but they also valued proper communication with the extended members and the larger community. Right from the beginning, they planned to "develop educational sessions, tools and resources regarding Pressure Ulcer prevention and improved

communication between sectors" (Firefly CoP Planning Document). The whole premise of the CoP initiative was to improve communication between different healthcare settings while the patients transitioned. In her first interview Olivia explained that "it was pretty clear that [they] needed to do something ... to assist in the transition between – and communication between – the sectors of care so that seemed to be a place... where there were gaps". Ann explained that the passport was developed to overcome this communication breakdown.

The CoP placed importance on proper communication not only within the CoP, but also between the CoP and other organizations, as well as between patients and healthcare providers. Olivia expressed the importance of getting "the information out to the right players". Ashley from the Firefly CoP also explained that there is a need for proper communication between different healthcare settings/organizations during patients' transitions; she mentioned that eventually, she hoped that the information that would be included in the passport could be communicated in electronic form.

Within the Mulberry CoP, although it was not as apparent, a lack of communication was still cited as a barrier to success. During a meeting, a researcher from the parent study team noted that

> [a Mulberry CoP member] went on to acknowledge that despite their best efforts, silos of care still exist and are strong – it takes time to build relationships and especially the element of trust. This is something her team has been working on diligently within their region, and although there have been some stumbling blocks; they are committed to breaking down these silos and ultimately enhancing care for the client. (Rachel's field notes from a Mulberry CoP planning meeting)

In addition to valuing proper communication, aspiring for a **working together** culture was also apparent in the CoPs. From the beginning the CoP members wanted to create a "place where people who are interested in wound care from not just the local level but on a national level, can really come together and have some, do research, have discussions, etcetera " (Olivia, Firefly CoP). Similar to the idea of communication, although participants aspired to work together, achieving such a culture in practice seemed more challenging for them.

In her interview, Jennifer, another Firefly CoP member, explained that the CoP worked together with nurses and registered practical nurses (RPNs). Furthermore, in her first interview, Wendy stated the following regarding working together with a relevant organization:

> So one of the groups that there has been in place in the province is a group that's an offshoot from the Registered Nurses Association of Ontario, and their group is called OntWIG, and so that's the Ontario Wound Care Interest Group, and they were really the first group that we sort of reached out to, to try and figure out what they were doing and to try and see if there were things that we could be doing together, again, to try and pull, a broader wound related group together. (Wendy, Firefly CoP)

In her first interview, Olivia explained that the wound care community, on a national scale, is a tight knit community. She stated that "it's small in terms of who is involved across the country" and that she knows "a large percentage of the people that are involved in wound care... across the country" (Olivia, Firefly CoP). Ashley also added to the notion of aspiring for a working together culture: "the way I look at it, we are all partners in healthcare and we should all be sharing and working with one another" (Ashley, Firefly CoP).

In relation to wanting to work together, there was a sense of learning together and especially teaching and educating extended members of the CoP who may not be as knowledgeable about wound care practices for older adults. Sarah was very articulate in demonstrating this idea:

> So I have a good basic knowledge but my staff don't... They are not nurses. But it is good for me because I can go out and teach them a lot of things... this is a challenge for me. It's not just about giving somebody a bath', because it isn't. (Sarah, Firefly CoP)

The Mulberry CoP also showed a sense of (aiming for) harmonious teamwork. For example, in regards to the start up of the CoP, Stephanie, a Mulberry CoP member said that a few members "who had an interest or who were actually actively participating... decided to come together as a working group to create some parameters to move [the initiative] forward and to create some form of standardization across the province" (Stephanie, Mulberry CoP). Furthermore, during a Mulberry CoP meeting, a parent study research team member noted that the CoP members strived to work together and that they found it vital for success because coming together provided support to the team as a whole.

Trying to support each other and work together meant that the CoP members strived to cultivate a **positive work environment**. They aspired for a "supportive environment to share ideas... [and] expertise and leadership within the planning group to move activities forward" (Rachel's Mulberry CoP meeting field notes). The members worked hard to maintain this positive work environment by trying to avoid unnecessary conflicts. This was more apparent in the Mulberry

CoP as the members did not seem to know each other as closely as the Firefly CoP members. For example, during a meeting lead by Jonathon, Rachel noted that the meeting ended with Jonathon suggesting that another individual take the lead on the next meeting because he "didn't want to step on any toes... or lead everything". Alex agreed that she would be willing to take on the lead during the subsequent meeting (Rachel's Mulberry CoP meeting field notes).

In order to maintain a harmonious work environment, a major concept that came through in the data was the **need for everybody to perform their assigned duties and fulfill their respective roles** in the team. For example, leaders need to take charge and lead by example, and facilitators need to take initiative to adequately facilitate efforts.

The CoP leaders had specific roles and duties in regards to the functioning of the CoP. A Firefly CoP document indicated that "Community of Practice (CoP) leads are responsible for preparing and submitting Activity/Outcome Reports ... every 6 months, as per [a] schedule" (Firefly CoP Activity Report Document). CoP "co-leads [were] also responsible for meeting schedules, agenda and recording of minutes. The addition of experts related to content, research and audience [were] accessible through the... membership of the CoP and additionally through relationships that exist[ed] with other CoPs" (Firefly CoP Document).

Compared to the Firefly CoP, the Mulberry CoP seemed to have more of a fluctuating leadership as described by Stephanie: "...well it fluctuates. There would be times where both myself and another member would take the lead and then there are other times where…as feedback was sought from other folks, it would switch back and forth" (Stephanie, Mulberry CoP).

Leadership, when it was adequately carried out, seemed to be a success factor for members. For example, Rachel's field notes during a Mulberry CoP meeting indicated that the group considered Brian their leader as he was well versed in complex care resolution as a clinician and therefore the members also valued his opinion (Rachel's Field Notes from Mulberry CoP Meeting). In addition to leadership, there were other roles played by different members of the CoPs. Although these individuals' responsibilities were different from those of the leaders, fulfilling these roles was just as vital for success. For example, Olivia expressed her appreciation for the assistance of a librarian who helped her search the literature regarding skin health, wound care and prevention. Olivia thought that it was "huge" to have access to library services and she

found the librarian a "great" and "wonderful" resource. Furthermore, Haley's field notes regarding the second webinar echoed the importance of different team members coming together to accomplish a task such as the webinar. She noted that different members carried out their respective duties, such as the technology/administrative manager helping with technical aspects, Patrick facilitating the session and the co-leads acting as primary presenters.

Different types of wound care **experts contributed different expertise** to the CoP. For example, Wendy's work was related to "embedding evidence into practice and moving the evidence out to the point of care so she brought explicit knowledge regarding literature and best practices to the table. On the other hand, Ann was "a practicing wound care specialist [and] was able to provide more of the sort of experience based knowledge" (Wendy, Firefly CoP). According to Wendy, the combination of these different experiences coming together "was a really good fit".

In the Mulberry CoP, "[Stephanie] was responsible for facilitating [one of] the meeting[s] as well as taking notes from the discussion. She was confident as a facilitator and was able to ask questions and seek clarification on comments when needed" (Rachel's Field Notes).

The importance of properly and responsibly carrying out assigned roles was strengthened by challenges arising when that did not take place. Although there was evidence of success regarding fulfilling assigned roles, there was also an incident where the CoP co-leads thought that the knowledge broker could be performing better. At one point, during her contexting interview, Ann thought that "[Patrick] was fantastic in keeping [them] organized and helping [them] with the reports". However, some time later, the co-leads expressed some dissatisfaction with his performance and how that was a barrier to success:

> you need to have a knowledge broker that's going to be engaged and able to facilitate…I think we had some issues around [that]… it's very difficult when you're doing a lot of other things and when you need to have someone who can be facilitating and optimizing the work; when that doesn't happen it really slows down the process… (Olivia, Firefly CoP)

> [Ann also] spoke of "administrative" problems, in that there were some people who were very involved with wound care and who wanted to be involved in the CoP, but who were not added to the memberships lists, and not receiving the information. She seemed to attribute this to issues with the administration through [Patrick] who she did not name directly. (Haley's Field Notes from Ann's Concluding Interview)

The conflict between the Firefly CoP co-leads and the knowledge broker lead to the conclusion that although the CoP members aspired to be a harmonious team that works together, this aspiration was not realized in practice.

The last aspect of aspiring for a harmonious environment concerned **discussions amongst the CoP members and between the CoP and other stakeholders**. The CoP members placed value on engaging in discussions regarding planning and carrying out initiative-related activities. The data contributing to the discussions aspect of working together came primarily from the Firefly CoP. For example, Haley's field notes from the second webinar explained the aspect of discussion amongst members, especially at the start of the CoP. She noted that the members were aware of the communication gaps between healthcare facilities during patients' transitions. They had "a number of discussions about how to best approach the issue" and acknowledged the fact that "patients manage their own care". The members held discussions not only to determine the direction of the initiative, but also to gain feedback on how to improve it. In contrast, the Mulberry CoP members did not explicitly cite discussion as vital for developing a harmonious teamwork environment.

Therefore, Both the Firefly and Mulberry CoP data demonstrated that members aspired for a harmonious, working together culture as they strived for proper communication, fulfilling their assigned roles, a positive work environment and engaging in discussions.

4.2.4 Striving for Strong Work Ethic and Good Practices to Achieve Efficiency and Productivity

A prominent theme amongst both the Firefly and Mulberry CoPs was working hard and adopting good practices in order to be productive and efficient. Since the CoP members were mostly working on CoP initiatives as an addition to their primary workload, it was important that they be efficient in their activities and efforts. This theme consisted of categories such as Hard Work Ethic, Setting Clear, Realistic Goals Together, Time Management, the Need for the Right Combination of Explicit and Tacit Knowledge, and generally Striving for Efficiency.

The members of both CoPs showed a habit of **working hard** to make a worthy contribution to their teams. This was apparent as many members often cited large workloads including labour

and time intensive administrative tasks, preparing and being thorough with work, traveling to events such as wound care related conferences, and a general desire to keep learning and growing. As Olivia put it, "[in] healthcare...everyone is working to the max" (Olivia, Firefly CoP). Ann also voiced the same notion during her first interview: "I've got this... pile of stuff on my desk... I keep thinking, 'Oh, I'll get this under control and it just keeps piling up'" (Ann, Firefly CoP). The participants also gave a sense of juggling various tasks and responsibilities and "how everything comes and hits your plate at once" (Jennifer, Firefly CoP). Olivia explained the time consuming administrative tasks as follows:

> ...there was a lot of paperwork that needed to be completed for the government…, through SHKN or SHRTN at the time, and that was really annoying... It wasn't just that it was annoying; it was very time consuming, labour intensive... and took away from our ability to actually do what we were trying to do. (Olivia, Firefly CoP)

Regardless of the large amount of work, CoP members continued to work hard and wanted to keep growing their knowledge base regarding wound care. For example, Ann mentioned a few conferences that she was going to attend. These conferences would provide her with knowledge, information and connections that could be used to further the CoP initiative. Mary, a First Nations nurse in the Firefly CoP "noted that [the] initiative was very relevant to her work with older adults, as participating in things like this [webinar] allows her to stay current with the knowledge on wound care" and allows for "professional development" (Mary, Firefly CoP). Sarah also re-iterated her and her colleagues' desire to keep learning:

> I took a wound management program at Mohawk College because I just wanted basic knowledge, more than when I'd been a nurse in training... I didn't have a lot of background so I took this program... After that when I started working permanently in the clinics, I had a lot of education from staff members... and I know I have got some PSWs that would be really keen, that would really enjoy having that knowledge because they are like little sponges, the majority of them. (Sarah, Firefly CoP)

When asked about how the Mulberry CoP's initiative first started in an interview, Jonathon explained that there "were more or less people who volunteered and it sort of came out of a meeting". The fact that individuals volunteered for the initiative, despite the work being "intense" (Jonathon, Mulberry CoP) shows a hard work ethic. The Mulberry CoP aimed to prepare for meetings, "for example, all key members would be provided with a synopsis of the situation in advance, they would know who would be leading the meeting... it would be more of a task group function" (Stephanie, Mulberry CoP). Additionally, the Mulberry CoP documents

(that showed the early aspects of the framework) demonstrated the fact that the members were thorough with their initiative and tried to account for all factors in a complex care case.

Although the CoP members showed a hard work ethic, it was important for them to be productive and efficient at the same time. This meant that they needed to **manage their time** and **set realistic, achievable goals as a team**. Several Firefly CoP members expressed that they were "crazy busy" (Ann, Firefly CoP). The fact that the CoP members (especially the leaders) had to write annual, lengthy administrative reports, took time and momentum away from focusing on the initiative itself as explained by Ann:

> I found it very difficult moving in these one year blocks with SHRTN and I really found that because it takes a lot of time to wrap it up and write reports and then write what you are going to do so you lose a lot of your momentum and then it almost feels like you're starting from the beginning again, to get that going. So I find... you're not just kind of slowly and consistently working through it the entire time. There really is some definitive points where you stop, right? Because you need to put a brake in it, write up your reports and do what you need to do…it felt like months and I think it is [emphasis] months actually... So I found that that was some lost time... to get the ball rolling again would take quite a bit of time because everyone's busy. (Ann, Firefly CoP)

With the Mulberry CoP, members did not explicitly talk about time management itself, but some of their comments did concern being busy in general and the lack of time to do various tasks. For example, during her interview, Stephanie explained that clinicians often don't have time to read lengthy documents and therefore need to be provided with concise, clear summaries.

In addition to time management despite a large workload and extensive reports, CoP members strove to embody good practices such as **setting achievable goals and holding realistic expectations**. This was, again, a lot more prominent in the Firefly CoP as compared to the Mulberry group. For example, when asked about how the Firefly CoP selected the passport as its initiative, Patrick and Ann explained that the CoP had looked at the gap in wound care-related communication in relation to the work they had done already. The CoP members used their experiences within the realm of wound care along with input from webinars to determine a goal they would be able to achieve. Ann further explained this as follows:

> ... there were all these different ideas that came out and that's why we decided we don't want those ideas because, how realistic... are we really going to be able to fulfill them, so

> let's focus our energy on something that can be done and that's when we started moving towards that communication tool. (Ann, Firefly CoP)

Realistic goals and expectations also came into play in regards to what the participants hoped the initiative would accomplish. CoP members seemed to be very aware of the fact that it would take time to implement the passport in practice. Olivia and Jennifer also seemed aware of the limitations of their work with the CoP and the fact that change is not immediate:

> ... it's the whole concept of knowledge to practice. Like, how do you move people from doing things the way they've always done it to changing the way they do things based on evidence, and wound care is a good example of how abysmal the knowledge translation actually is. It takes forever. (Olivia, Firefly CoP)

Similarly, even in the later stages of the passport initiative, members were aware that "there's a big difference between having people read an article and having people actually implement" (Olivia, Firefly CoP). Moreover, when asked about the implications and changes potentially brought about by the initiative, Olivia stated the following:

> I mean it's too early to [know. You] put something like this out and it takes a long time to actually begin to see things happening... I just know this from health care that if it's not right there in front of your face with a big banner that says "click here for the My Skin Health Passport, print off the free downloadable..." , no one will do it...I don't care how good it is. No one will look for it..... So I'm not saying that to be... negative, I'm just saying that that's the reality, certainly in health care is that because there is just so much going on. (Olivia, Firefly CoP)

Holding realistic expectations and striving for achievable goals allowed the CoPs to be more efficient. However, the participants seemed aware that **efficiency and productivity** needed constant attention. For example, Olivia said, "... it's just really difficult to necessarily get things organised exactly the way you'd like them or get the people involved because everyone's really busy" (Olivia, Firefly CoP). Due to awareness of such challenges, the members often voiced the opinion that there is a need to be productive and efficient in CoP practices. For example, Jennifer stated:

> you need that foundation to make sure that you know exactly where you're going and also to provide some form of accountability in that process... And that's where caution would need to be exercised to make it actually practical? To take it from that theoretical mode into more of an applicable component...there also need to be firm deadlines and people who are truly committed. (Jennifer, Mulberry CoP)

Another aspect of efficiency came through in the form of using technological tools during the process of disseminating the initiative. "There was a lot of use of technology, especially social media platforms like twitter, LinkedIn, and YouTube" that was used by the Firefly CoP for promoting the initiative (Emily, Firefly CoP). Furthermore, the CoP members tried to be relevant to the current workings of the healthcare system in relation to wound care. While thinking about dissemination and uptake of the passport, they tried to use accreditation requirements to their advantage, as explained by Olivia below:

> ... the next step is ... if people can implement it… in the hospital, for example, with the new accreditation expectation for 2015, ... one of the program requirements… is to have something around preventing skin breakdown… so anybody who was at the session or who has seen that document would say, "oh, well, we could implement this"... that would be a way to demonstrate for accreditation Canada that we're doing something... so I think it's—timing is very good. (Olivia, Firefly CoP)

The last aspect of efficiency that came through in the theme concerning good practices by CoP members was using a **balance of explicit and tacit knowledge**. Using both explicit and tacit knowledge in a CoP initiative may lead to efficiency because it means that the CoP is engaging in evidence-based and context-specific practice in order to generate a credible and pragmatic product. The participants showed that they knew the value of using knowledge both from the literature as well as professional and patient experiences. As indicated by Patrick, knowledge that was used as background for the CoP initiative was "based on the literature, of course, evidence and people in actual practice and what we think might be helpful" (Patrick, Firefly CoP). Furthermore, Haley's field notes from the two webinars echoed the value the CoP members placed on using a balanced combination of explicit and tacit knowledge by incorporating literature, personal experience, feedback from webinars and by "providing examples of cases where the tool could be useful in practice".

Similar to the Firefly CoP, the Mulberry CoP also demonstrated attention to the balance between explicit and tacit knowledge. When asked what types of knowledge are important when developing CoP initiatives and documents, Stephanie stated:

> I think both [experiential and scientific knowledge] are... huge... because I think certainly literature you turn to best practice in those types of things, but there's also nuances and experiences that are also equally of value... that contribute to the overall picture. But there definitely needs to be that balance (Stephanie, Mulberry CoP)

The field notes written by Rachel echoed the Mulberry CoP using both explicit and tacit knowledge as they drew on a framework for guidance and aimed to use "sample cases to help support development of their model".

Therefore, CoP members working in both Firefly and Mulberry CoPs seemed to strive for efficiency and productivity through hard work. Although members reported working hard, they also found it important to manage their time, set achievable goals and hold realistic expectations. Being efficient included incorporating both explicit and tacit knowledge. Due to a lack of time and due to some members working on the initiative (especially in the Firefly CoP) in their relatively scarce spare time, it seemed important to the members to not waste time and effort.

4.2.5 Tensions, Worries and Uncertainty

The last emergent theme concerned an array of ideas that indicated the presence of some professional tensions, worries and uncertainty. Within this theme, there were main ideas including friction amongst professionals, competition with similar groups, concerns regarding funding as well as general uncertainty and instability. Some of these issues were internal to the CoP whereas others concerned external individuals or organizations. This theme was also primarily interpreted from the Firefly CoP data. However, there were also some references made by the Mulberry CoP members regarding the presence of competing perspectives and uncertainty about the future.

Some of the **professional tensions** that emerged from external individuals or groups concerned lack of cooperation by the members' colleagues in the extended Firefly CoP community. For example, Patrick mentioned that the CoP faced some challenges that were "political in nature" due to "different camps within wound care" (Patrick, Firefly CoP).

Similarly, Olivia and Ann provided explanations regarding the challenge of getting healthcare providers to change and adapt something new like the My Skin Health Passport:

> ... as long as we still have physicians – the requirement for physician orders for wound care, you’re not going to get change happening as rapidly as we would like because you have to still go through that step with physicians who know nothing about wound care. They have no education on wound care in their programs and yet they think that somehow they’re the keystone, that they have to be in the loop. And they don’t, often

> they don’t. So a lot of doctors are really fine, but it’s an extra step that a nurse has to go through and it’s an unnecessary barrier so if you put barriers in the way for people to do things and it just makes life really difficult. (Olivia, Firefly CoP)

In terms of professional friction internal to the Firefly CoP, participants placed value on proper facilitation by the knowledge broker, and how hindering it can be to success if there isn't adequate facilitation within the CoP and among the CoP and other stakeholders. Since the co-leads expressed dissatisfaction with Patrick's performance, it was interpreted as professional tension within the CoP, amongst members. The following quote by Olivia extensively demonstrates friction as a result of this dissatisfaction:

> ... to be perfectly honest – I’m not sure we had really the best support from our knowledge broker... it could be because [he] was involved in a number of other initiatives or… I don’t know... It’s hard to do this off the side of your desk... this is a kind of volunteer component of what you do and it just was frustrating to not have someone who would be really on the ball with it... I guess my thinking is, someone who’s being paid to do this, I expected to have more… support, more assistance… to move this stuff forward instead of just saying, 'so…..' [and] the other person who was stepping in as the knowledge broker while he was off, we set up a webinar, she contacted people – she did all kinds of stuff... you would think that our knowledge broker would have picked up on that and gone, 'Oh, we should be doing some things in conjunction', right? And that never happened... I’m not blaming the knowledge broker but I’m just saying that there wasn’t a whole lot of anything [emphasis] that came out of… I mean, you’re getting paid to do it, you know? (Olivia, Firefly CoP)

Haley's field notes from an interview with Ann also showed her dissatisfaction with Patrick. Contrary to Olivia and Ann, Patrick did not seem to detect any friction or tension. The following excerpt from Haley's field notes demonstrates his point of view:

> After learning about the tensions between the CoP co-leads and the [knowledge broker], I was curious to hear [Patrick]’s side of the story. [His] final reflections reinforced the communication issues within the CoP. [Patrick] noted that he had thought the co-leads had terminated their involvement with the CoP, so he began to search for new leaders to move the CoP forward. From his interview, it did not seem as though there any tensions from his perspective; it was only an issue of miscommunication, as he will continue to work with one of the co-leads in future CoP activities. (Haley's Field Notes after Patrick's Interview)

The professional tension between the Firefly CoP co-leads and the knowledge broker could have been a result of a lack of communication. It is difficult to determine which side (if either) is at

fault as both sides perceived shortcomings in the other. Regardless, this conflict, although not monumental, was important to acknowledge as an aspect of the Firefly CoP dynamic.

In addition to friction within the Firefly CoP, there was also external tension that seemed to be derived from a sense of **competition with organizations doing work in wound care**. "From the very get go [it] was a concern for [the Firefly CoP] to make sure that [they were] not overlapping any of the other services that were out there" (Ann, Firefly CoP). "They searched for a gap in knowledge and found that gap to be within transitions of care." (Haley's Field Notes from Patrick's Contexting Interview). Ann explained that there are several organization working in wound care and the CoP wanted ensure that they were "complementing all the other organizations and not competing with them" (Ann, Firefly CoP). She further said that even when they would do webinars and realize that another organization was holding a similar event, they would contact them to collaborate but found that "a lot of those organizations and those groups, [worked] independently" and did not want to collaborate (Ann, Firefly CoP).

Although it was not as prominent and there was no explicit mention of competing organizations, the Mulberry CoP members also referenced a few instances where different **professional perspectives were challenging to navigate**. Stephanie explained this notion as follows:

> I think one of our challenges is that across all of the areas we are so different [in terms of professional backgrounds] and we have different visions as well as different sort of instructions from our individual LHINs around what things... need to look like... And so I think that was part of our challenge as well... (Stephanie, Mulberry CoP)

Within the Tensions, Worries and Uncertainty theme, one of the most prominent issues was **tension regarding funding and its availability**. At first, it did not seem like a very significant issue. However, as data analysis continued, it became apparent that this concern was common amongst members. There were several instances where participants brought up the fact that CoP activities would possibly be coming to an end due to funding also coming to an end. In relation to funding, participants also mentioned the fact that they were volunteering their time for CoP initiatives. Volunteering did not seem to be an ideal option for participants, and not just because they were busy with other work. This could also be seen as dissatisfaction with compensation for the work performed by CoP members, which was interpreted as professional tension. Olivia was the most expressive about the tension caused by a lack of funding. She did not appreciate

working hard without compensation. The following quotes demonstrate the professional friction felt by Olivia:

> ... money has to be put into it, resources have to be put into doing something like this, and if they're not put in, if it's on the side of the table, then that's where it stays... It's depressing but that's just the way the world works. (Olivia, Firefly CoP)

> Given the fact that [Patrick] is getting paid… he e-mailed us to say he wanted to set up a survey, another survey of people who were at the webinar and maybe another webinar... we're the ones who were doing the work of putting the webinar together... But... we're not doing this as part of our current jobs. So it's a disincentive… there is a difference between doing something for an organization where everyone is a volunteer as opposed [to this]... so this presents some other challenges I guess... it's a bit of disincentive... Our understanding was that we were basically done... Like, that this community of practice was finished, we had done our job, we're done. Now... [somebody else] needs to take this on... where it's considered part of their role, because, I do consulting work and I would be fine to do this if [they were] willing to pay me... the incentive for us to do this is because we are nurses and because we're interested and keen and whatever but to be doing this as a volunteer is not exactly... balanced. (Olivia, Firefly CoP)

A lack of funding not only created a sense of dissatisfaction amongst the CoP members, but it also caused tension and confusion regarding CoP members' exit from the CoP. Regarding the CoP folding due to end of funding, Olivia expressed the following:

> I think it's unfortunate that this whole sort of program is being disconnected or whatever..., frankly, I think it's really short sighted of the government that… They do a lot of very short sighted things so…What else is new? (Olivia, Firefly CoP)

Haley's field notes also re-iterated the confusion surrounding the Firefly CoP co-leads' exits. Therefore, concerns regarding funding contributed significantly to the Firefly CoP developing a partly negative atmosphere. However, this issue was solely observed in the data from the Firefly CoP. In addition to friction caused due to concerns regarding (lack of) funding, the last main idea that contributed to the Tensions, Worries and Uncertainty theme was **uncertainty and instability**. Firstly, uncertainty existed regarding the Firefly initiative's potential and whether it was considered valuable and useable by stakeholders. For example, Ann and Mary stated:

> I think that's where… we ended up missing that loop. So if it has been implemented, I am not really sure. I am not really sure how it's going... Because we haven't heard back from that one webinar where you had listened in on it. We haven't heard back from any of the participants whether or not it is something that they are using. (Ann, Firefly CoP)

> I think [the passport] would have to be piloted. I don't think I could say for sure whether they would use it or not. I think it is of value for sure, I'm just not sure without testing it as to whether it would be used or not. (Mary, Firefly CoP)

There was also a sense of uncertainty and instability regarding the Firefly CoP membership, as some CoP members were not on the email list and therefore we not informed of the initiative's progress and events such as the webinar. Furthermore, the ending of the CoP was also confusing and unclear for the members, especially the knowledge broker and the co-leads. The following quotes extensively demonstrate this confusion and uncertainty from Patrick's point of view:

> One was the instability of SHKN as a whole over the past year in terms of being told that we were being linked as a wind down year, and unclear about what was going to happen come March 31st. And then the same for the community of practice itself, was that it was – and I was assuming that it was winding down, but in fact, they were still people and the people who said they were winding down still wanted to be involved... Having a stable environment within which to work [is important]. Although I think SHKN was fairly stable over the year, but there was lingering questions about what was going to happen, so it did take away people's energy from focusing on the actual task at hand... (Patrick, Firefly CoP)

When the CoP's relationship with SHKN ended, "nobody seem[ed] to know what's happening, …and [members had] been going on the premise that [they were] done but "[they] didn't know if there would really be anybody... who's going to move it forward..." (Ann, Firefly CoP).

With the Mulberry CoP, although there were a few references that were interpreted as uncertainty, overall there was minimal data related to tension. For example, since the Mulberry CoP had not had any activity for months at the time of Stephanie's interview, the interviewer asked her whether there was any upcoming initiatives and efforts. She replied as follows:

> Not at this time because this group is actually a sub-group of the operations table, and the operations table is still undergoing some restructuring and so forth and looking at accountability practices and such. That's been shifted as a priority. And the sub-group has stagnated a bit until such time that the operations group is flowing more effectively. (Stephanie, Mulberry CoP)

Similarly, when asked if there were any knowledge exchange activities planned for getting this the Mulberry CoP initiative out to a broader audience, Jonathon stated:

> At this point Rachel, I'm really sorry I don't know. I don't know where sort of they're at. Here at the Southeast LHIN, we fleshed out that provincial framework a little bit more,

> like I said with consultation with CCAC and we've sent that off to the LHIN but I don't know where that is right now. (Jonathon, Mulberry CoP)

Therefore, instances regarding interprofessional friction, unhealthy competition, dissatisfaction with funding, uncertainty and instability contributed to a sub-culture of tension among the CoPs in this study and provided insight regarding barriers to CoP success.

4.3 Summary of Results and Findings

In summary, five major themes emerged from the data in this study. Both the Firefly and Mulberry CoPs hoped to achieve success and influence change within the healthcare system using their respective CoP initiatives. The Firefly CoP showed an appreciation for incorporating diverse professionals, perspectives and experiences in the CoP initiative, although this was not always evident in practice. Similarly, although it did not necessarily translate into action, both CoPs aspired to work together as harmonious teams while striving to cultivate an open and positive work environment. The Firefly and Mulberry CoPs also tried to employ good practices such as time management and setting realistic goals in order to strive for productivity and efficiency. Lastly, there were some tensions, uncertainties and worries amongst the CoPs, especially in relation to funding, unhealthy competition and some minor professional conflicts.

Chapter 5

5 Discussion

This secondary qualitative analysis used an ethnographic approach to explore the culture and success factors of two SHKN CoPs from the perspectives of the CoP members. The CoPs included in this study worked in the areas of wound care and complex care resolution for older adults in Ontario. This chapter discusses the emergent themes in relation to the CoP literature. The differences between the findings for the Firefly and Mulberry CoPs are also discussed, as are the research findings in the context of the study research questions. The chapter concludes with the first author's reflections about conducting this study as a constructivist and a Health Information Science student.

5.1 Study Findings in Relation to Research Questions

This study explored the culture and success factors of CoPs through the perspectives of their members. The research questions were: 1) As a member, what culture and values are associated with being part of a CoP?, and 2) What should a successful CoP look like according to members?

Different themes contributed different amounts of data to answering the research questions. For example, the theme surrounding diversity was only apparent in the Firefly community and partially answered the research question regarding culture. Similarly, the concerns and tension regarding funding were also only prevalent in the Firefly community. Table 5 in Section 5.2 summarizes the contribution of themes and categories to the two research questions. While all themes contained aspects that contributed to both research questions, overall, themes seemed to contribute more to answering either the question related to culture or the question related to success factors.

5.1.1 Culture

There were times when the CoPs were not acting as synergistic, united teams; however, they strived for the togetherness of the group. Therefore, **aspiring for a harmonious environment and working together** as an integrated CoP was an important cultural aspect for the study's

CoPs. In addition to aspiring for harmony, the members' passion for the cause as well care for the initiative was demonstrated. Members **wanted to change** services for the better and were fearful about potential failure. What is notable for those wanting to nurture CoPs is that cultural attitudes are difficult to fabricate. Individuals working towards something (such as the CoP members in this study striving for positive change) must possess a sense of dedication and wanting to work together. Similarly, Krawczyk, Hamilton-Bruce, Koblar, and Crichton (2014) studied a translational research team and found that the team resembled a community of practice that was passionate about their research topic. Jennings Mabery, Gibbs-Scharf, and Bara (2013) suggest that "factors contributing to the overall success of the CoP [include] having the right people involved in creating and managing the CoP [and] and having committed and engaged CoP members" (p. 231). Like this study, the notion of passion, harmony, cohesion and related concepts feature strongly in the CoP literature. As a final example, a study regarding virtual CoPs discussed the importance of commitment and engagement:

> "barrier [to success] involves the shifting membership of a virtual CoP which... is fluid in its composition. In consequence, virtual CoPs need to work hard to maintain energy and a high degree of participation. Individual members of a virtual community must engage with it in order that it may develop and grow and have meaning." (Gannon-Leary& Fontainha, 2007, p. 4)

Attitudes and values such as passion, commitment and dedication are difficult to produce and extract from individuals as they are usually something that people embody. Although an organization/leadership cannot force members to be passionate or impose a sense of harmony, such cultural aspects can be actively encouraged. To foster a culture of passion and ambitiousness in CoPs, perhaps it is best for members to form the group on their own, as opposed to an organization selecting individuals and forming the CoP. If members come together themselves to form a CoP and choose a topic of interest within their domain, they may be more likely to care about the cause and subsequently be passionate about CoP initiatives. This means that perhaps the recent shift in thinking about CoPs (e.g., the change from organic emergence to formal formation) may not prove beneficial in terms of fostering a passionate and ambitious culture (Wenger 1998; Wenger, 2011).

Pyrko and colleagues (2017) raise the point that an important aspect of successful CoPs is the process of "thinking together" (p. 389), which involves the members sharing tacit knowledge in order to come together to help each other understand concepts and collectively work through problems within the CoP's domain. Interestingly, Pyrko and colleagues (2017) argue that communities of practice don't formally "think together", but rather the process of "thinking together" is responsible for the emergence of a meaningful community of practice. This was more apparent in the Mulberry CoP than the Firefly CoP. There did not seem to be many instances where CoP members had to help each other understand wound care related problems as the focus was on working through dissemination problems as opposed to building a framework based on complex care guidelines (in the Mulberry CoP). This could be due to the nature of the CoP initiatives, as the Firefly CoP had more of a directed focus with the passport, whereas the Mulberry CoP's goal of building a complex care framework was less tangible and more conceptually challenging.

Fulfilling team roles was another important point of resonance between the study's findings and the literature. Challenges in carrying out a facilitation role impacted the ability to effectively work together and fulfill assigned team roles. It can also be considered a cause of professional tension among members if individual responsibilities are not carried out effectively. Similarly, the review conducted by Li and colleagues (2009b) stated that CoPs place high value on facilitators, to a point that "some linked the success and failure of the CoP to this role" (Li et al., 2009b, p. 5). At the same time, Li and colleagues (2009b) also noted that

> "the actual responsibilities of facilitators and the organizational support required for this role were less clear in the literature. For example, some facilitators played a distinct role from that of the leader and conducted their activities under the direction of the group and/or the leader, while other groups merged the role of the leader and facilitator." (Li et al. 2009b, p. 5)

Other scholars have determined that although it is important to have leadership and facilitation, these two roles are different (Barnett et al., 2012). These roles often overlap in CoPs. In our study, although the CoP leads (i.e., in the Firefly CoP) engaged in some facilitation efforts, there was an actual member of the CoP, Patrick (the knowledge broker) who was explicitly

responsible for facilitation. It seemed that his role was important to the CoP's success. Therefore, effective facilitation can be considered a necessary success factor for CoPs. Based on our study's findings (especially regarding the Firefly CoP), perhaps it is an advantage to have flexibility in roles concerning leadership and facilitation. It may be useful to have multiple members in the CoP carry out a facilitative role. Findings showed that since there was only one individual formally designated as a facilitator, the co-leads had concerns regarding his performance. If there had been another facilitator in the group, perhaps the CoP could have utilized that individual's expertise instead of relying on just one person.

Hemmasi and Csanda (2009) aimed to "explore the impact of select Community of Practice characteristics on overall community effectiveness and community members' satisfaction with their community experience" (p. 262). They chose specific factors to explore including leadership quality, commitment to the community and its goals, members' perceived connectedness with others in the community, trust, and perceived impact of CP involvement on members' own jobs. The results of this study suggested a correlation between effectively incorporating all these factors and CoP success (Hemmasi & Csanda, 2009). These findings are like ours as some CoP members in our study drew motivation from personally knowing someone affected by wound care issues. Investment and motivation based on personal experiences can be a significant contributor to the passionate culture of a CoP. Unfortunately, this is an aspect that could be difficult to obtain or predict in members as CoPs and their parent organizations cannot request individuals to be members based on their past or personal experiences. However, concepts such as leadership, connectedness and trust may be established through sharing, interaction and a sense of democracy in the group. If the CoP members themselves choose or elect a leader and/or facilitator, they are probably more likely to follow their lead and feel less unequal in ranking. Leaders and facilitators can perhaps encourage trust, commitment and connectedness by paying close attention to being part of the team as a regular member as opposed to an authoritative figure. These issues are probably best dealt with internally by the CoP as opposed to a parent organization imposing suggestions or rules. Working together to determine roles and responsibilities within a CoP could facilitate a culture of togetherness and harmony. Barnett and colleagues (2012) developed a framework regarding factors that may contribute to the success of a CoP including facilitation to "promote engagement and maintain community standards" (p. 10). Something additional that was proposed in the framework was an

initial "champion" stakeholder to jump start an initiative. The framework also stressed some other key success factors such as "a supportive and positive culture that is both safe for members, and encouraging of participation", the value of "benchmarking and feedback" as well the effective use of technology (Barnett et al., 2012, p. 10). These findings are similar to ours as we also noticed that the CoP members valued engagement, commitment and participation, especially those working in wound care. In the Firefly CoP, although there was an initial champion stakeholder in the form of a steering committee, this steering committee was not involved in the later stages of the CoP. Perhaps the initial champion stakeholder should not only be involved during the beginning of a CoP, but should also participate throughout the CoP processes and efforts. In regards to the CoPs in our study and other healthcare CoPs, it may be beneficial if one of the champion(s) is a knowledge end user such as a patient or caregiver. Having an end user as a champion could be beneficial because such an individual will probably have interest in a CoP initiative based on personal experiences and therefore may be more committed and engaged.

Ideas such as a positive learning climate, sharing experiences and discussions that emerged in the analysis have been found by others (Giusti, Perra, & Lombardo, 2017). However, contrary to Giusti and colleagues (2017), CoP members in this study did not necessarily place importance on constructing a sense of identity. This may be due to the fact the CoPs in this study were formally generated and already had a collective identity at the outset. In regards to identity and being recognized as a CoP, it is probably better for CoPs to be, again, formed naturally. If a CoP that is naturally formed achieves a sense of identity, it is likely to be stronger than that of a formally formed CoP.

In addition to aspiring for harmony and passion, the other important cultural characteristic was **worries concerning the funding** within the Firefly CoP. Not only did the Firefly CoP members bring up this issue, but they also spoke about it passionately. Tension surrounding funding was not expected to be so prevalent based on previous findings in the literature. Concerns regarding financial compensation may not immediately seem an obvious aspect of a CoP's culture. However, financial compensation probably represents acknowledgement, appreciation and a sense of security for CoP members. If an organization such as SHKN is sponsoring or overseeing a CoP, perhaps members and the CoP can be rewarded upon achieving milestones. Based on our study participants' opinions regarding funding, CoPs and their parent organizations should

probably pay close attention to not only rewarding the CoP as a group, but also acknowledging and compensating individuals (Jeon, Kim, & Koh, 2011). This may lead to a sense of pride and security for the members, which can help the CoP last longer and accomplish more goals.

5.1.2 Success Factors

Several CoP members demonstrated the importance of working hard to achieve goals. The study participants strived for a **strong work ethic** by trying to manage their time and balance large workloads while being extremely busy. Although it may seem obvious, a strong work ethic, and factors such as passion and harmony, are difficult to produce or fabricate by others for members of a CoP or other healthcare team members. In our study, the participants demonstrated a strong work ethic and passion for wound care/complex care resolution before becoming CoP members, especially as many of them volunteered their time for the initiative. However, it may be possible that it they were being financially compensated, they would have possessed an even stronger work ethic. Another point of consideration is whether the CoP members had these attributes before coming together or whether the CoP somehow cultivated them. Although we cannot claim this with any certainty, it is more likely that the participants generally had a strong work ethic which transferred to CoP practices.

Just as we discovered in our study, the notion of CoP members sharing tacit and explicit knowledge with co-workers is another common idea related to CoPs (Gannon-Leary & Fontainha, 2007). Meagher-Stewart and colleagues (2012) also found that incorporating tacit and explicit knowledge effectively is a vital success factor in decision making. Furthermore, Giusti and colleagues (2017) determined that some weaknesses and threats to CoP success included "poor representation of some relevant stakeholders" (p. 7). In our study, CoPs strived to account for patient perspectives through incorporating their past professional experiences, especially when determining the direction for the CoP. However, it seems that perhaps they did not use patient perspectives as much once the initiative was already derived. However, members demonstrated an aspiration for including all stakeholders, so this aspect could be explored in further research. Including both tacit (especially from patients) and explicit knowledge in CoP initiatives can lead to more credible and pragmatic products that would perhaps be more receptive to dissemination and uptake efforts.

According to Retna and Ng (2011), other factors important for CoP success include leadership, organizational culture as well as "individual motivation to learn" (p. 41). Retna and Ng (2011) also mentioned the need for adequate time management, but that it "should be considered by the leadership of the organisation" (p 55). Challenges for CoP success may include "hierarchical relationships [inhibiting] plain participation", a lack of "active management", a "sense of not belonging for member joining the CoP later", "too many topics for discussion", "absence of regional managers and decision-makers", "time constraints" and "difficulties in valuing and giving external visibility to the intangible outcomes of the CoP" (Giusti et al., 2017, p 7). Most of the barriers to success discussed by Giusti and colleagues (2017) came up in this study as well. Members mentioned the importance of time management; however, they did not express the opinion that time management as a group should primarily be the leaderships' responsibility. Perhaps this is because the two participants who contributed the most data to the study were both CoP co-leads themselves. They seemed to do the bulk of the work anyways, so perhaps they would not want to commit to additional responsibilities. In terms of CoPs in general, although leadership should oversee the group and have more responsibilities (such as facilitating time management), perhaps it may help to have more multiple leaders (similar to facilitation). Multiple leaders in a CoP may help avoid hierarchical divisions and an unequal distribution of work. In terms of time management, CoPs (whether informal or formal) should pace themselves and should constantly perform (informal) self-evaluations regarding progress.

The fourth theme in our study represents ideas relating to effective, productive, good practices that members can employ to work towards success as a CoP. Others have shown that such practices could include involving the end-user in development (Kwak, Wåhlin, Stigmar, & Jensen, 2017), leadership support (Kwak et al., 2017), and clear purpose and goals (Kwak et al., 2017; Barnett et al., 2012; Gannon-Leary & Fontainha, 2007). This is in line with our findings as there were instances during data collection when the members expressed the importance of involving patients and setting clear, realistic goals and expectations. The idea of leaders explicitly working on setting realistic goals, however, was not as apparent in our data since the nature of each initiative was determined by a steering committee at the beginning of the CoP. Setting realistic goals can be difficult for CoPs if they are over-ambitious or if they are unable to judge the time and effort needed for a particular initiative. This can perhaps be addressed by

ensuring to refer to relevant literature in detail before embarking on an initiative to get an idea for the amount of time and resources spent on similar efforts.

Another success factor was the **value of incorporating diverse professionals, experiences and perspectives** in the CoP initiative. A study concluded that "the presence of professionals with diverse perspectives" acted as a facilitator for successful continuing professional development (Barry, Kuijer-Siebelink, Nieuwenhuis, & Scherpbier-de Haan, 2017, p. 185). Barnett and colleagues (2012) also suggested that "boundary spanning" can facilitate success through interacting with different professional groups and using external experts (p. 1). Boundary spanning is related to our theme regarding the CoP members appreciating collaborations. In relation to the CoPs, although it was not always translated into action, it was clear that the members valued including diverse opinions and perspectives. Diversity is important because it provides the opportunity to incorporate multiple perspectives while analyzing a health issue. This can help provide context-specific care to patients. Although CoPs usually focus on particular issues/initiatives which seems to make them unidisciplinary in terms of their goals, they may (and perhaps should) be multidisciplinary in their membership by involving diverse individuals from and professionals from different disciplines.

Including diverse perspectives external to the immediate CoP membership also needs to be mindfully carried out as it may lead to tension and friction. Barnett and colleagues (2017) mentioned that it is important to have a "broad church" (i.e., involvement of various stakeholders) (p. 10). However, they also noted that CoPs should ensure that "the church is not too broad" (p. 10). This is exactly the same notion that was discussed by some of the Firefly CoP members in regards to competing for the same dissemination audience with similar organizations working in wound care. Therefore, it would probably be helpful for CoPs to find a balance between incorporating all stakeholders while still making sure that there are not so many competing perspectives that it leads to counter-productive competition. This balance may sometimes be difficult to achieve in practice, but it can perhaps be monitored and facilitated by CoP leaders and facilitators.

Bindels and colleagues (2014) suggest that it is important to create "ownership among CoP members" (p. 115) including patients. In our study, the Firefly CoP members also stressed

involving patients' perspectives as part of implementing the passport. However, contrary to Bindels and colleagues (2014), our study did not have CoP members report resistance by the patients. This might be because patients were not personally involved in the planning and implementation of the passport and the CoP ended before they could really see whether the passport was being used by patients during transitions between healthcare settings.

The last major success factor for the CoPs was the importance of **proper communication**. Members valued adequate communication amongst themselves, between different health sectors and even between healthcare providers and patients. A lack of communication between health sectors seemed to be a trigger for the beginnings of both CoPs. A lack of communication within the CoP itself was also observed as a barrier to success. Proper communication is difficult to manipulate, and was therefore highlighted. Gannon-Leary and Fontainha (2007) found that communication is vital for CoP success because it helps build trust and community. These findings mirror the success factors described by our study's participants as they strongly believed in the value of effective communication and working together. However, as the participants' actions showed, proper communication is challenging to achieve in practice. Open communication may become easier if a CoP is a well-functioning team and members are honest with each other. Similarly, external communication between CoPs and relevant stakeholders could be effective if all parties involved actively try to understand each others' perspectives and work towards a common goal.

It is important to note that in some instances, it is difficult to distinguish between cultural aspects and success factors. For example, the notions of diversity and communication can be considered both in relation to culture and success. For the purpose of this study, themes were placed in either category based on the participants' perspectives and the analyst's interpretation. For example, the CoP members stressed the importance of proper communication and including diverse perspectives and stakeholders. Since the CoPs were engaged in knowledge translation initiatives, a diverse membership and perspectives seems to be more of a success factor than a cultural aspect as it was more evident in the members' aspirations rather than their actions. Communication was seen as a success factor as the lack of communication lead to challenges for the CoPs. Similarly, although working as a harmonious team is vital for success, the way

participants aspired for such a dynamic was more indicative of their values and beliefs rather than a factor may lead to success.

5.2 Similarities and Differences Between the Firefly and the Mulberry Communities of Practice

Some ideas were mentioned by participants more frequently whereas some were talked about more intensively. For example, the importance of communication was one of the most frequent ideas that emerged in the data for both CoPs. Dissatisfaction with funding and lack of compensation was not mentioned as frequently, but participants seemed to talk about it more intensively. Generally, intense ideas seemed to be of a higher importance to members than those that were mentioned more frequently. The analysis illustrates certain similarities and differences between the Firefly and the Mulberry CoPs. It is important to note, again, that most of the data that contributed to themes came from the Firefly CoP. Four out of five themes emerged in both CoPs: both CoPs' members expressed passion, a hope to cause change, aspired to work together as a harmonious team, strived for a strong work ethic thorough good practices, and experienced tension, worries and uncertainties. Only the Firefly CoP members demonstrated their value of diversity in membership and perspectives (see Table 5 below). This might be because there was minimal data available for the Mulberry CoP, suggesting that we should not assume that the Mulberry CoP did not value diversity. On the other hand, the possibility of members not acknowledging the need for diversity or failing to incorporate it could have been (partially) responsible for the Mulberry CoP dissolving.

Data about worries and tension caused by funding concerns were only prevalent in the Firefly CoP. The Mulberry CoP was not successful in continuing past some preliminary meetings. This finding can be linked back to Wenger's theory about CoPs (2011). The fact that the Mulberry CoP did not continue could be due to a lack of the key elements described by Wenger (2011). The absence of experts and leaders, along with the change in individuals' commitment to the CoP, may have prevented the group from developing a culture that fostered harmonious teamwork. This study suggests that the absence of the necessary cultural and success factors described in this study led to the Mulberry CoP being unsuccessful. Without further research it

would be difficult to determine which of these two scenarios was the cause of the Mulberry CoP's demise.

The following table summarizes and compares which themes and associated categories emerged through the Firefly and Mulberry CoP datasets. It also demonstrates the contributions of each theme to the research questions (i.e., regarding culture or success factors).

Theme	Categories	Emergent in Firefly CoP Data?	Emergent in Mulberry CoP Data?	Contribution to question regarding culture?	Contribution to question regarding success factors?
Hope and Desire to Cause Real, Effective Change	Commitment and Engagement to Cause (Importance and Lack of)	Yes	Yes	Yes (more so than success factors)	Yes
	Passion for Cause	Yes	Yes		
	Aspiring for Improvement (Self and System)	Yes	Yes		
	Fear of Futile Efforts	Yes	No		
	Finding Encouragement and Motivation in Incremental Successes	Yes	No		
	Desire to Make a Difference	Yes	No		
Appreciation for Bringing Together Diverse People and Experiences	Professional Collaboration	Yes	No	Yes	Yes (more so than culture)
	Aiming for Patient Consideration and Involvement	Yes	No		
	Value of (Extended) Member Input and Feedback	Yes	No		
	Appreciating Diversity in Professions and Experience	Yes	No		
	Drawing on Personal Experience	Yes	No		
Aspiring to Work Together as a Harmonious Team	Communication (Importance and Lack of)	Yes	Yes	Yes (more so than success factors)	Yes
	Aiming to Work Together	Yes	No		
	Importance of Fulfilling Assigned Team Roles	Yes	No		
	Importance of Discussions	Yes	No		
	Leadership	Yes	(No)*		
	Need for Specific Experts and Leadership	(No)*	Yes		
	(Importance of) Facilitation	(No)*	Yes		
	Striving for a Positive Work Environment	(No)*	Yes		
Striving for Strong Work Ethic and Good Practices	Setting Realistic Expectations and Goals	Yes	Yes	Yes	Yes (more so than culture)
	Time Management (Importance of and Challenges)	Yes	Yes		

to Achieve Efficiency and Productivity	Need for the Right Combination of Explicit and Tacit Knowledge	Yes	Yes		
	Value of and Striving for Efficiency	Yes	No		
	(Hard) Work Ethic	Yes	Yes		
Tensions, Worries and Uncertainty	Professional Tensions	Yes	No	Yes	Yes
	Concerns Regarding Working Without Funding	Yes	No		
	Uncertainty	Yes	No		
	Competition with Other Groups for Originality	Yes	No		
	Instability	Yes	No		
	Presence of Competing Perspectives	(No)*	Yes		
	Uncertainty about Future	(No)*	Yes		

Table 5: A Comparison of the Themes and Categories in the Firefly and Mulberry CoPs. Asterisks indicate categories that were only slightly different in the two CoPs and hence were given slightly different names.

5.3 Study Strengths and Limitations

5.3.1 Study Strengths

This study's findings demonstrate some unique strengths. Firstly, this study provides an example of a secondary qualitative analysis, a type of study that is not often conducted within qualitative research. Therefore, this study is an example for other researchers aiming to conduct secondary analysis, especially from a constructivist lens and using an ethnographic approach. This study can help provide guidance regarding the strengths and limitations of secondary qualitative research in general.

We adhered to our research questions and focused on the perspectives of the participants to enhance credibility. We also attempted to include quotes from every participant, as well as include an extensive number of quotes in the findings to align with a constructivist and ethnographic approach. This study strived for "meaningful coherence" by using "methods and procedures that fit its stated goals" as well as interconnecting the study findings and interpretations to relevant literature (Tracy, 2010, p. 840).

5.3.2 Study Limitations

Since this study was a secondary ethnographic analysis, there are some limitations that must be acknowledged. For example, the parent study team did not explicitly declare their paradigmatic stance, whereas the paradigm used to guide this study was constructivism. This has implications regarding meaningful coherence of the study (Tracy, 2010), i.e., that the methodologies used in data collection and analysis could be different. Since this is a constructivist secondary analysis, a lack of coherence does not make the findings any less "reliable" but it may affect their plausibility and resonance.

Additionally, although this is a constructivist study and the sample size is not aiming for representativeness, it would have been beneficial to interview more CoP members. Some voices (for example, Anna and Olivia) were more prevalent than others as they were CoP leads and therefore had more experiences to discuss. Also, since the first author did not collect the data, it can be argued that she did not have as much interaction with it as compared to the primary data collector. However, the analyst attempted to recontextualize the data as much as possible by reading background material about the parent study as well as the CoPs, in addition to reading the data thoroughly. The fact that we were not able to collect any additional data was a limitation. In ethnographies (as with several qualitative methodologies), when uncertainties or gaps arise during data analysis, researchers usually collect more data to resolve uncertainties and clarify experiences. A better understanding of some findings might have occurred with additional data collection (e.g., absence of an appreciation for diversity in the Mulberry CoP).

Since this is a constructivist secondary ethnography, there is no right or wrong interpretation of the data; however, it is important to include different perspectives in coding and analysis (Guba & Lincoln, 1994). The first author primarily coded and performed the secondary analysis. However, at various stages of analysis (for example, after generating raw codes, after generating categories and after formulating themes), the primary supervisor was engaged by sharing codes, categories and themes for discussion. The research supervisor and committee members could determine the plausibility of the codes, categories and themes by proposing alternative interpretations. The student's committee members were all involved in the initial study and data collection and therefore could also assess the plausibility of the results. Furthermore, although

the field notes and observation notes were not written by the first author, they were still included in the analysis to allow for different perspectives.

5.4 Significance of Findings for Practice

The findings in this study may be useful on a larger scale in terms of CoPs' contribution to the healthcare sector. The themes discussed here may hold resonance for other CoPs that may choose to foster the cultural aspects and embody the success factors discussed. If the cultural aspects and success factors mentioned here are consciously incorporated, it may help nurture well-functioning CoPs. Well-functioning CoPs can arguably have a positive influence on the healthcare system by encouraging collaboration between sectors/organizations and breaking down communication barriers. Effective CoPs may also contribute to better understandings and provide new knowledge regarding health issues for not only older adults, but also other populations.

5.5 Personal Reflections

This study was conducted through a constructivist lens, an approach requiring reflection about the entire research process. The following is a summarized reflection written by the first author; detailed reflexive notes and analytic memos can be found in Appendices B and C.

> After much reading and learning about alternative paradigms in qualitative research, I could adapt to viewing this study through a constructivist lens. Before this study, I identified as a post-positivist, primarily because I was not even aware of the existence of alternative paradigms. However, once I started exploring CoPs, and especially after formulating a research direction and questions, it was hard to ignore the fact that the same idea/concept can have as many interpretations and the number of interpreters.
>
> My interpretations must have been shaped by literature around CoPs that I read in knowledge translation-related courses and over the course of this study. For example, much of the literature talks about the important of leadership, communication and facilitation. I was also hesitant to read the case reports formulated by the parent study team to avoid unnecessary pre-assumptions; however, I made sure not to read their results and discussions sections, and only paid attention to the sections containing background explanations about the CoPs.
>
> At the beginning of this study, it was very difficult to come to terms with analyzing data that I had not collected. I feel as though I could spend an endless amount of time further

examining the results and exploring even more connections between what the participants expressed. Previously, I also worried that I would not be able to connect to the data or be able to truly understand the participants' perspectives. However, I found that the parent study team members who collected the data, transcribed interviews and wrote field notes did so in a way that really focused on the study participants and allowed me to relate to the data.

I feel that it is important to reflect on a conversation with Dr. Conklin regarding the findings. Upon discussion with him about an early draft of the results section, he mentioned that perhaps I had been too optimistic in presenting the CoPs' culture (primarily the Firefly CoP). He mentioned that the perspectives of the participants demonstrated their aspirations rather than their actions. When I reflected upon the analysis stage after this discussion, it was hard to "unsee" this notion. I agreed with Dr. Conklin regarding this nuance and made changes accordingly.

Overall, this has been a great learning experience. I feel that this study has not only taught me a lot about the workings of CoPs in relation to knowledge translation, but I have also learned to see the Canadian healthcare system from a different perspective.

5.6 Conclusion

This study aimed to learn about the culture and success factors of a wound care and a complex care resolution CoP from the perspective of the CoP members. We used a secondary ethnographic approach to explore the research questions from a constructivist stance. There were five themes that emerged from the data in this study. In terms of cultural aspects, an analysis of members' views resulted in themes about: aspiring for a harmonious, working together culture, passion for the CoP's cause; and worries and uncertainties surrounding (a lack of) funding. Regarding key success factors, we suggest that the three most important findings from our study include: a strong work ethic, incorporating diverse perspectives and experiences through collaboration and involving all stakeholders, and striving for proper communication. There was an overarching aspirational culture among the CoP members which suggests that the implications discussed in this study are perhaps much harder to implement in practice.

We cannot make any knowledge claims or suggest definitive facts regarding CoPs, as this work was conducted from a constructivist lens, which means that the findings in this study are specific to the Firefly and the Mulberry CoPs. However, the (general) findings of this study might resonate for other CoPs and other professional teams/groups. Based on the study's findings, we suggest that future studies could look towards exploring how CoPs work together as teams to

achieve synergy. Future work might also examine the dynamic between internal versus external factors contributing to tensions, worries and uncertainties within and around CoPs. It would also be beneficial to explore the role and perspectives of patients or end knowledge users associated with CoP initiatives.

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Appendix A: Knowledge Translation

Knowledge Translation (KT)

> The Canadian Institutes of Health Research (CIHR) defines knowledge translation as a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system. This process takes place within a complex system of interactions between researchers and knowledge users which may vary in intensity, complexity and level of engagement depending on the nature of the research and the findings as well as the needs of the particular knowledge user. (CIHR, http://www.cihr-irsc.gc.ca/e/29418.html).

Synthesis. In the context of knowledge translation, the synthesis aspect concerns using results and findings from research studies within a particular area/topic of interest in a contextualized and integrated manner. Although this can be accomplished by utilizing either/both quantitative or qualitative avenues, the synthesis process must be transparent (CIHR, http://www.cihr-irsc.gc.ca). A synthesis could be anything from a systematic literature review to an executive summary of a conference presentation or a set of best practice guidelines.

Dissemination. The dissemination aspect of KT involves getting the synthesized information to the right audience in the right form, medium and manner which is contextualized and context-specific (CIHR, http://www.cihr-irsc.gc.ca). Dissemination of health information in KT can be accomplished through activities such as "summaries for/briefings to stakeholders, educational sessions with patients, practitioners and/or policy makers, engaging knowledge users in developing and executing dissemination/implementation plan, tools creation, and media engagement" (CIHR, http://www.cihr-irsc.gc.ca).

Exchange. The exchange aspect of knowledge translation occurs through "mutual learning" and involves interaction between the knowledge producers (which are often researchers) and knowledge users such as patients, practitioners and policy/decision makers (CIHR, http://www.cihr-irsc.gc.ca) (The Canadian Foundation for Healthcare Improvement (CFHI, http://www.cfhi-fcass.ca). Mutual learning occurs "through the process of planning, producing, disseminating, and applying existing or new research in decision-making" (CFHI, http://www.cfhi-fcass.ca/).

Ethically-sound application of knowledge. It is important for KT initiatives to adhere to the law and society's ethical and moral values "while keeping in mind that principles, values and laws can compete among and between each other at any given point in time" (CIHR, http://www.cihr-irsc.gc.ca). Knowledge application, when successful and effective, is an iterative process of utilizing research to inform practice and decisions. Therefore, it is vital to constantly and effectively evaluate the knowledge translation process and strategies being employed in any KT initiative (CIHR, http://www.cihr-irsc.gc.ca).

Knowledge to Action (KTA)

According to CIHR, an ideal KTA process is comprised of phases relating to knowledge generation and action (CIHR, http://www.cihr-irsc.gc.ca). Producing knowledge is not enough- it needs to be "distilled" into an appropriate format in order to be applied and inform action (CIHR, http://www.cihr-irsc.gc.ca). The KTA process can be considered a cycle as action that leads to "implementation or application of knowledge" (CIHR, http://www.cihr-irsc.gc.ca). The following figure illustrates the KTA process as outlined by the CIHR:

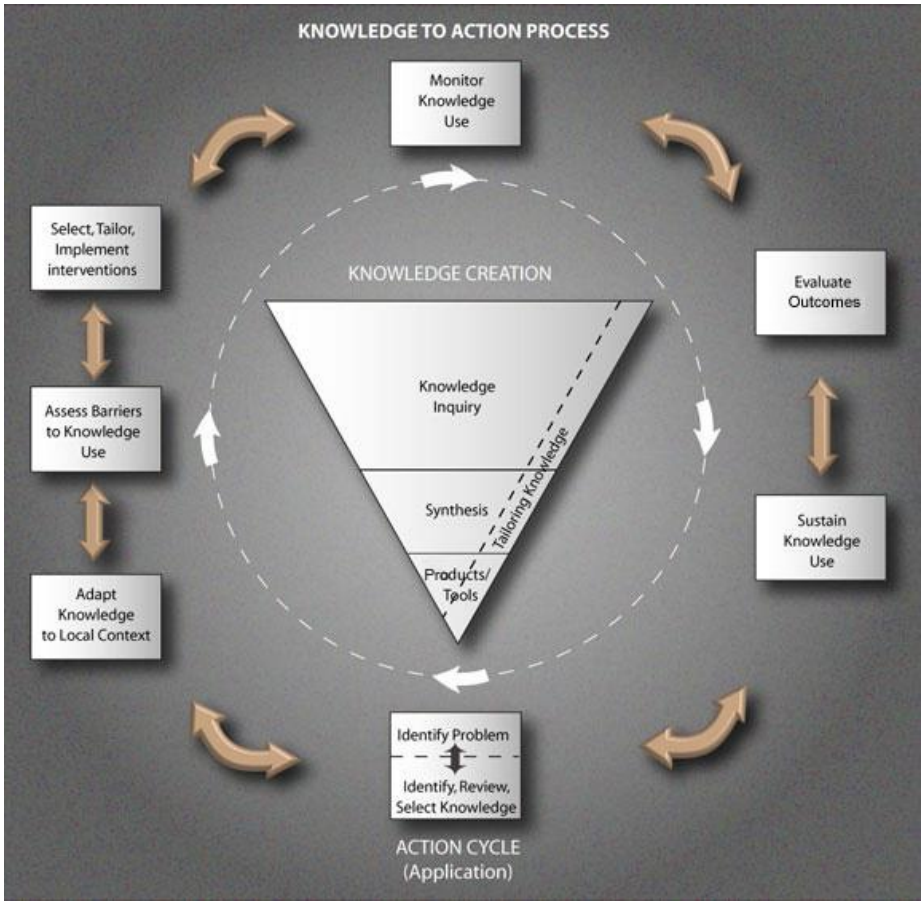

Figure 2: The Knowledge to Action (KTA) Process (CIHR, http://www.cihr-irsc.gc.ca)

Appendix B: Reflexive Notes

Reflexive Note 1: How do I Determine my Paradigm?

I completed my undergraduate education at McMaster University with a major degree in Biochemistry and a minor in French Studies. Coming into the Health Information Science program at Western University, I can safely say that I did not even know the true meaning of the word, "qualitative", let alone qualitative research. The only time I can recall even hearing the word spoken by an instructor or professor was ironically in the second year Statistics course when we discussed the difference between quantitative variables (such as height) and those that are qualitative (such as the colour of an object).

When I decided that I want to conduct qualitative research for my Master's thesis, I knew that I had a challenging road ahead of me. I started reading literature regarding qualitative research during the 2016 summer, and I must admit that almost none of it made any sense to me. Having taken the Qualitative Research Methods course, I think that is because I believe that an individual's paradigm is shaped through life experiences, education and several influences at different points in life. Before taking this course, I was not even aware of the spectrum of paradigms ranging from positivism to critical theory. I always knew that we, as humans, go through life and make decisions based on beliefs, values and opinions that are a part of our identity. I just never realized that in the context of research, you could put a name to this set of worldviews held by a person.

I spent the better part of the 2016 summer desperately attempting to identify with one particular paradigm. Knowing what I know about various paradigms, I was undoubtedly and completely a post-positivist at the beginning of this Master's program. I am undoubtedly no longer a *complete* post-positivist. When we talked about the example of Pluto's (non)status as a planet in the Qualitative class, I definitely identified as a post-positivist. However, when talked about health-related concepts such as pain or life with an illness/disease, I was a constructivist as I could no longer look at individuals separately from the illness/disease. So since my graduate program concerns healthcare, I decided to place myself within a constructivist box with large enough holes that the box can be broken without herculean effort. This is partly because I felt that I needed to finally identify with a paradigm to properly conduct coherent research for my thesis. I

suspect that with time and advancement of my educational and research career, I will be able to better solidify my paradigm- perhaps it will change as well and I may move in either direction!

Reflexive Note 2: Valuing Different Perspectives

At the beginning of this program, if someone was to tell me that pain is a phenomenon that can manifest itself in varying realities, I would not have been able to accept this notion. The fact that I had such a difficult time placing myself within a particular paradigm may stem from my reality of simultaneously identifying with different aspects of various paradigms. Although I consider myself a constructivist at the moment, I feel that I might change my position based on the situation presented to me. For example, I would consider myself a critical theorist if confronted with an issue regarding the lack of healthcare services available to women in war-torn, developing countries. On the other hand, if I am confronted with a decision regarding the best drug for my illness, I would definitely take a post-positivist approach and choose the one that performed the best in randomized control trials.

The point here is not that I may fluctuate between paradigms. I think that this uncertainty has actually been beneficial for me. It has allowed me to realize the value of different perspectives, both in research and in everyday life. Even if I do not agree with the ontological and epistemological assumptions of a positivist or a critical theorist, I feel that I am now better equipped to appreciate their position. This seems extremely important in overcoming barriers that are put up *by* researchers *for* researchers.

Reflexive Note 3: Thoughts on Secondary Qualitative Research

Until a year ago, conducting a secondary analysis for my Master's thesis had not even crossed my mind as a possibility. I guess I was indifferent about the merit of secondary analysis in qualitative research. However, if I think back to my thoughts, values and beliefs at the beginning of this program, it is probably safe to say that given the choice, I would have definitely picked a primary study over secondary analysis.

I identified my first supervisor and project topic quite early in the program. I was excited to embark on a journey that would allow me to develop my own study, recruit and interview my own participants and analyze data that I collected. A background in biochemistry had me

thinking about all these stages of a project in a certain way. However, after we learned about grounded theory and I determined it as the methodology for my first project, I was introduced to several new ideas and concepts. My favourite and most interesting part of conducting a grounded theory study was theoretical sampling. I had never thought that data could be analyzed in a comparative manner and analysis of earlier data could guide subsequent sampling and recruitment. Therefore, I was really looking forward to exploring and engaging in theoretical sampling. Perhaps I was most excited for the potential connections and conversations with participants that awaited me.

Unfortunately, due to circumstances beyond my control, I had to change my thesis project. It is more unfortunate that the situation did not allow me to carry my previous research project over to working with Dr. Kothari. Since I was beyond excited to interview participants and collect my own data, this change was a discouraging one. For a while, I was seriously doubting my ability to finish my degree within a reasonable time frame. Therefore, I must admit that I was extremely relieved to learn that I still had a working chance of completing my degree on time with a new, secondary analysis project. That is partly because I neither had to sample participants nor collect data or submit an application for ethics approval. Secondary analysis, by no means, takes minimal time. However, there was comfort in knowing that I did not have to start right from square one.

Reflexive Note 4: Personal Issues with Secondary Analysis and the Reality of Research

Although there are mixed perspectives regarding the merit of secondary qualitative research, I believe that it deserves more credit. My experiences as a graduate student have allowed me to better realize the importance and merit of secondary qualitative research (see Reflexive Note 2). Although the majority of researchers and students would probably prefer to be conducting primary studies with their own participants and data, the reality of research for beginners, especially students, can often be quite different.

Firstly, obtaining funding can be a significant challenge for students beginning their career in research. Even when funding is acquired, it is always for a limited amount of time, which places strict deadlines on students and research supervisors. Furthermore, certain aspects of conducting research at the graduate level may not always be in the control of the student. For example,

during my personal experience, the situation of changing projects meant that I had to re-start. If such a situation arises and a student switches projects mid-program, the deadline for primary funding and completing the degree remains unchanged. These are only some of the challenges faced by researchers, especially students. Others may include delays in projects due to challenges in determining coherent methodology and analytical techniques as well as recruiting participants.

Some of these challenges can be overcome by secondary analysis projects as some of their primary advantages concern time and cost efficiency. Although it is perhaps not the best idea to think of research in terms of efficiency and ease (for the lack of a better word), the reality of time, funding and other issues that are out of a researcher's control cannot be ignored. Secondary qualitative analysis should not be used as a "back-up plan" for when a particular project changes course unexpectedly. Universities and research institutions need to realize and acknowledge the aforementioned issues by not only offering more secondary qualitative research avenues, but also facilitating students and researchers through adequate training.

As mentioned in Reflexive Note 2, I was thrilled to get the opportunity to work on a secondary analysis project for my Master's thesis. However, as a constructivist, there was definitely some uneasiness regarding the trajectory of my project, especially when I first started exploring the possibilities in relation to the larger study. For example, I found it extremely difficult to determine the analytical approach that would be best suited for the research questions, and required extensive expert help. This is partly due to the fact that the original researchers did not seem to explicitly identify a specific paradigm or methodology that guided sampling and data collection. It is implied that they are most likely post-positivist, but placing the larger study within a paradigm can be a difficult task that may not be able to be accomplished without detailed discussion. Since determining an ethnographic analytical approach for my thesis, I was also nervous about fairly using all types of data collected such as observational and field notes.

Reflexive Note 5: Reading the Individual and Cross-Case Reports

During the process of selecting CoPs to analyze, I read the cross-case reports and individual cross-case reports for all CoPs and all three years of data collection. I did not look at the analysis sections of these reports much at all (just skimmed over them very quickly), so I wouldn't say they've had much effect on my interpretation of the data. Almost all the content I read in these

reports was descriptive accounts of the CoPs, which helped me select the CoPs to analyze for this study. However, I do feel like reading these reports had an impact on determining the methodology for the study. These reports seemed to have taken a narrative/case study approach so that's what helped me decide to go with an ethnographic approach for this study. Once I had read over the descriptions, I did not return to look at either the individual or the cross-case reports. However, I guess the case reports might have made me look out for KT-related data (e.g., regarding evidence use, dissemination etc.) more than if I hadn't read them. Regardless, when I was analyzing data, I consciously made an effort to stick to coding only in relation to my research questions.

Reflexive Note 6: Analysis Framework

When I mentioned the notion of looking for a potential framework (for analysis) that has a cultural aspect to it, Anita agreed with the overall idea of needing such a framework as this is an ethnographic study. However, she brought up a good point in terms of *when* the framework would be used. Basically, what we decided was that I could start analysis since that will involve answering my research questions. The framework itself would come into play most probably when I would organize my analysis and results, for example into themes. Using the framework *to* analyze doesn't coincide with being constructivist- that would be a post-positivist approach. So we decided that I would hold off on this and start with analysis. As of early June, I had been analyzing data without a framework in mind. Later, we tried to frame the analysis according to Wenger's CoP theory, but found that it didn't work well, so I continued analysis and writing without explicitly tying everything to a framework.

Reflexive Note 7: Data Anonymity

When I received the data for the Mulberry CoP, I noticed that there were names in the transcripts, so I stopped reading any further and closed the files. During my subsequent meeting with Anita, the point of confidentiality was brought up and she mentioned that I'll have to sign an agreement adhering to the confidentiality and ethical protocols as outlined by the parent study.

In regards to de-identifying data myself for this sub-study, Anita suggested that I assign numbers and letters to signify different people that hold different roles. My first thought was that I like

pseudonyms (actual, common names) more because they make the story-telling aspect of qualitative research more relatable. However, I decided that if there were various types of participants in the data (such as individuals, organizations, teams etc.) it might be better to do what Anita suggested.

Since this is a constructivist study focusing on an interpretation of the participants' voices, it makes sense to use several, detailed accounts relating to the research questions. This study adhered to ethical protocols, which was especially important as I was not part of the parent study team and did not collect the data. I worked with data that had been de-identified previously by the parent study team. Pseudonyms were used to refer to participants while reporting findings. We used actual names as opposed to alpha-numerical codes as that will hopefully contribute to telling a story and help the reader better resonate with the participants' perspectives.

Reflexive Note 8: Accessing Data

Unfortunately, it was not possible for me to access the audio recordings of the interview transcripts. We were also only able to obtain 19 of the total 49 documents for the Firefly CoP. However, as most of the analysis was based on participants' interview transcripts and the parent study researchers' field notes, the team did not believe that this was a detrimental limitation.

Reflexive Note 10: Tracy's Criteria

We tried to adhere to Tracy's (2010) quality standards to the best of our ability. Hence, this study demonstrates strengths in regards to that as well. For example, CoPs are a "worthy topic" (Tracy, 2010, p. 840) to study as communities of practice are becoming more and more prevalent in healthcare and need to be explored (Thomson, Schneider, & Wright, 2013). We also attempted to conduct a rigorous study by using Wenger's theoretical construct (2011) as a sensitizing concept for relating the findings to current literature. Also, since this study is based on a secondary analysis, we tried our best to be transparent about not only the benefits of such a study, but also its pitfalls, in order to achieve sincerity (Tracy, 2010).

Reflexive Note 11: Team Members Unable to Code all Data

It is important to include different perspectives in a research study. Although it would have been ideal for various team members to code all the data independently and then come together to account for different perspectives, it was not feasible for all research team members to code and analyze the transcripts and notes due to practical constraints, especially difficult deadlines. This would be something I would change if I had more time or an opportunity to re-do this project.

Reflexive Note 12: Multivocality and Culture Limitations

In regards to the results themselves, the amount of data that contributed to the themes was obviously skewed in favour of the Firefly CoP. Some CoP members also contributed more data than others. However, that can be attributed to the nature of the roles members possessed. For example, individuals like Ann and Olivia, who were CoP co-leads clearly carried out more responsibilities, and therefore had more to say regarding the functioning of the CoP. Lastly, culture, itself, is quite an ambiguous social idea. Therefore, it can be difficult to make claims regarding the culture of loosely coupled groups such as the CoPs in this study. However, since this is a constructivist study, these findings represent solely one plausible interpretation of the data. The findings in regards to culture concerned values, beliefs and attitudes held by the CoP members in relation to their work, as opposed to something that would be a result of prolonged and repeated interaction.

Appendix C: Analytical Memos

Memo 1: Importing Data into NVivo and Uncoding

I imported all the data for the Firefly CoP from the most recent file sent by Rachel (including the CoP documents). There didn't seem to be 49 CoP documents as outlined in the Firefly case report, but these documents were not going to be the focus of the analysis anyways, so analysis was started with the transcripts.

The data that I received already had coding done upon it. I did not read any of these codes. I uncoded all data so I could start fresh with analysis. The data for the Firefly CoP was already de-identified, but I had to de-identify the data for the Mulberry CoP.

Memo 2: During Reading the First Interview Transcript

It looks like the CoP was formally formed, and professionals deliberately came together to work on improving communication regarding the patients' wound care needs as they move through different healthcare settings. This idea of proper communication seemed to be very important to the participants so far as it has already surfaced multiple times. There seems to be a genuine care among the participants regarding patients' wound care needs.

Memo 3: Detailed Explanation of the Analytical Approach

We used the approach described by Spradley (1980) to analyze data for ethnographies. The approach focuses on behaviour; however, in this study, behaviour *along with* perspective, values and beliefs were also looked at in relation to the research questions. Spradley's (1980) approach consists of three stages including domain analysis, taxonomic analysis and componential analysis.

During the domain analysis stage, we looked at different initial codes and how certain codes related to each other through descriptive and values coding (Saldana, 2009; Spradley, 1980). In addition to Spradley (1980), the data analysis can also be considered as a two-cycle approach. For example, domain and taxonomic analysis involved descriptive coding as well as values coding. According to Saldana (2009), descriptive and values coding approaches are part of "first

cycle" coding. First cycle coding in qualitative research refers to the initial stages of coding that are direct and simpler than coding in later stages (Saldana, 2009). "Ethnographic studies usually begin with ... general questions [like] 'What is going on here?' and 'What is this a study about?' Descriptive Coding is [an] approach to analyzing the data's basic topics to assist with answering [such] questions" (Saldana, 2009, p. 70). Values coding refers to "the application of codes onto qualitative data that reflect a participant's values, attitudes and beliefs, representing his/her perspectives or worldview" (Saldana, 2009, p. 89). During the first-cycle coding, I began with an inductive approach. Analysis began with open coding to produce "raw", initial codes from the verbatim transcripts, field notes and observational notes. This was carried out by first reading the transcripts/notes while simultaneously making initial notes and memos about key ideas (Williamson, 2008). We chose descriptive and values coding because they allowed flexibility with analysis specific to our research question. For example, descriptive coding is applicable to studies with various types of data (as in our case) such as interview transcripts, observation notes and field notes (Saldana, 2009). Descriptive coding allowed us to come up with initial codes from these various types of data with the same, overarching research questions. Values coding was specifically in line with our study as one of the research questions directly looked at the cultural values of CoP members. Similar to descriptive coding, values coding can also be applied to studies with different sorts of data sources (Saldana, 2009). We continued domain analysis through descriptive and values coding until relationships between cultural values, beliefs, and experiences emerged and formed categories (Spradley, 1980). This helped make connections between the participants' words and cultural values related to the research questions.

After domain analysis, Spradley (1980) suggests taxonomic analysis. During this stage, I organized the cultural domains that emerged as a result of domain analysis. This was achieved by comparing and contrasting different codes and categories to find patterns (Spradley, 1980). Throughout the process of coding and determining general and specific categories, I attempted to continually organize the categories by thinking deeply about the relationships, similarities and differences between them (Williamson, 2008). Taxonomic analysis helped form connections between the larger, encompassing ideas from the previous analytical stages. During the taxonomic analysis stage, I also found that some categories could be considered sub-categories of others. Taxonomic analysis also included descriptive and values coding (Saldana, 2009).

The final stage of analysis was componential analysis (Spradley, 1980). According to Spradley (1980), componential analysis is the “systematic search for attributes (components of meaning) associated with cultural categories” (p.131). "The attributes of a cultural category are its unique characteristics that are consistently present and clearly separate from other categories... Componential analysis is [meant] to find differences in attributes and determine how they are connected to a theoretical framework" (Robinson, 2013, p. 17). Within componential analysis, I utilized a "pattern coding approach", which is a second cycle coding strategy (Saldana, 2009). Second cycle coding refers to later stages of coding that involve "analytic skills as classifying, prioritizing, integrating, synthesizing, abstracting, conceptualizing, and theory building" (Saldana, 2009, p. 45). Pattern coding refers to deriving codes that are "explanatory or inferential [and] identify an emergent theme, configuration, or explanation [by grouping various initial codes] into ... meaningful and parsimonious unit[s] of analysis... [such as] themes, or constructs" (Miles & Huberman, 1994, p. 69). I utilized pattern to coding as a part of componential analysis. Pattern coding was suitable for this study because it is applicable to studies that aim to develop themes from data by "examining social networks and patterns of human relationships" (Saldana, 2009, p. 152). Taking into account my constructivist position, we did not seek out a theoretical framework to apply to the results. The results were reported as overarching themes with subthemes.

Memo 4: After Completing the Initial, Open Coding for all Four Contexting Interviews and Accompanying Field Notes

There seemed to be a concern regarding funding and its availability. There were several instances where participants brought up the fact that CoP activities would possibly be coming to an end due to funding also coming to an end. In relation to funding, participants also mentioned the fact that they are volunteering their time for CoP initiatives. The fact that the participants expressed their work as volunteerism suggests an altruistic nature of CoP members. However, this could also be interpreted as dissatisfaction with compensation for the work performed by CoP members.

Another idea that seemed to come up a lot during the contexting interviews was the concept of communication. Communication was discussed by all participants several times. Sometimes, it

was mentioned in the context of a lack of communication between various healthcare settings treating the same patient. Additionally, participants also talked about communication within the CoP, both in terms of its importance and sometimes the lack thereof. Although it seems trivial that proper communication is vital for the success of a CoP initiative, the participants' perspective and words demonstrates the fact that proper, effective communication is a challenging goal when several stakeholders are involved in a conversation regarding a care plan for a patient.

There seemed to be a genuine sense of care for the patients' well being among all participants who were interviewed. Genuine care for the patients seemed to be a point of agreement for all CoP members. Similarly, all the CoP members seemed to care about involving not only the patients, but also their families, in their care. This may be because KT efforts in relation to evidence-based medicine have started to put a lot more focus on involving patients and families in healthcare delivery plans. If this is indeed the case, it demonstrates the fact the CoP members make an effort to keep up with changes in the healthcare system as well as changes in the way care is delivered.

Participants also stressed the importance of the accessibility of the CoP initiative they were developing. A number of times, CoP members mentioned the fact that the passport was not branded and that they would make it available for any organization to use. The fact that the CoP and its members were not concerned with branding their product and taking ownership of the passport also shows a genuine sense of care for the patients, and the hunger for success. In relation to that, all the dissemination efforts almost make it seem like there is a fear of failure and a significant fear of their work going unnoticed among the CoP members.

It also seemed very important to the CoP members that they acquire and incorporate other members' input in developing the passport. In terms of feedback, they tried to get it from other, indirect members of the CoP such as individuals attending the webinar. This demonstrated the fact that CoPs constantly focus on improving initiatives and efforts.

Memo 5: After Initial Coding of the First KTA Event's Field Notes

Overall, it seemed like the leaders of the CoP really strived to explain the CoP initiative to the audience attending the webinar. Individuals attending the webinar can be considered informal members of the CoP as well. Although they are not explicitly said to be members of the CoP, their involvement in the webinar and the more general area of wound care sort of makes them "extended" members.

Field notes from the first webinar brought about some of the same ideas I noticed in the contexting interviews, for example, requesting feedback, showing a genuine care for patients, placing importance on proper communication. Just as the interviewer mentioned in their field notes, I also felt like the CoP members placed a huge importance on feedback from stakeholders and really welcomed suggestions for improving the passport. I've thought a lot about the definition of a CoP member. So far, I still consider individuals who attended the webinar to be members of the overarching Firefly CoP, although they may not directly contribute information and knowledge as compared to the formal members.

Memo 6: After Initial Coding of the Concluding Interviews and Accompanying Field Notes

The concluding interviews re-iterated the things and patterns that I started to see in the other data sources. For example, I, again, saw that ideas such as genuine concern for patients, the concept of communication and getting the word out there about the CoP initiative was important to the participants interviewed. I also saw the fact that CoPs and what they do was very complex in terms of connections within the CoP and connections that CoP members had outside of the explicitly declared group of CoP members. Participants talked often about using personal and professional connections to either disseminate the initiative or CoP products, or for the general purpose of wanting to teach other professionals who may not know about the CoP initiative but could use it to improve their work and care delivery for patients. At this point, I had started to notice that many of the same ideas are coming up again and again. However, I didn't believe I had reached "saturation". There are a few things coming up that seem to be new ideas.

Memo 7: After Initial Coding of the First KTA Event's Field Notes

This KTA event was another webinar. I saw a lot of the similar codes come up in the field notes for this event as the transcripts for interviews conducted before this event. The field notes for this

webinar were written well. These field notes give me the sense that the CoP members really value the input and feedback of the extended CoP members. It was really important for them to create an open and encouraging environment in order to promote discussion and feedback regarding the CoP initiative (i.e., the My Skin Health Passport). My thought that successful dissemination was extremely important to the CoP was also echoed by these field notes. This is probably because this CoP was engaged in KT and the whole purpose of KT is to get the right knowledge to the right people. Therefore, it makes sense that the members would want to disseminate the initiative as much as possible. However, I almost got a sense that CoP members were fearful of their work getting lost or their efforts being futile if dissemination of the initiative was not successful.

Memo 8: After Initial Coding of the Final Follow-Up Interviews and Accompanying Field Notes

The final follow up interviews weren't really bringing up any new big ideas in relation to the research questions. However, coding these transcripts did give me a better view of the value participants place on proper facilitation by the knowledge broker, and how hindering it can be to success if there isn't adequate facilitation within the CoP and among CoP and other stakeholders. The idea of proper communication came up again in these transcripts. I also confirmed my thoughts that volunteering was really not an ideal situation for the participants. Obviously, I cannot say this with certainty as I was not the data collector but I got the sense that the participants did not want to be volunteering their time and efforts, not just because they were busy with other work. I think that this is a good point to stop the initial coding because I don't really see any new big ideas emerging and I also feel like I've reached elastic saturation. I'll still code all the CoP documents to see what emerges through them.

Memo 9: After Coding all the CoP Documents for the Firefly CoP

Although the documents did not yield any new big ideas, I did learn something new from them in terms of the entire KT process employed by the Firefly CoP. The documents showed that there is a lot of planning that went into the formation of the CoP and its actions. It seemed like the CoP really had a good grasp on factors (such as making professional connections, proper communication and working together) that would be vital for success. Since many of the documents were from before the CoP formally began, they showed an ideal scenario of how the

Firefly CoP should (have) run. However, looking back at the transcripts, it seems apparent that the reality of the situation was different. Although the CoP was able to achieve the main goal of developing the initiative, the process didn't unfold exactly how they envisioned it would. This notion makes me think about KT and overall change in the healthcare system. Throughout the course of this program, that is one notion that I have realized is true: whether it is policy making, implementing best practice guidelines or the KT initiatives carried out by a CoP, things never go according to the idealistic plan set before starting.

Memo10: After Coding All Data for the Mulberry CoP

Since there was not as much data for the Mulberry CoP as compared to the Firefly CoP, it did not take me as long to code it. I coded all the data before writing this memo. In terms of codes, nothing new really came through that stuck out. There were quite a lot of ideas that came through in the Mulberry CoP that were also present in the Firefly data (for example, the importance of communication, working together and the lack of time). It's important to note that this CoP dissolved and was not able to continue enough to achieve its goals. From the transcripts, I could infer that the cause for the premature end of this CoP was the fact that the priorities of the people involved in it changed over time. Although members of this CoP wanted to revisit the initiative at a point, it didn't seem like that happened. One idea that came to mind regarding the "failure" of this CoP is that the nature of its work was a lot more complicated than that of the Firefly CoP. The Firefly CoP was developing one single passport, whereas the Mulberry CoP was working on developing a detailed framework that required input from a lot more (often hard to reach) stakeholders. The data for this Cop also did not contain as much about the concern regarding the lack or end of funding.

Memo 11: During Taxonomic Analysis of the Mulberry CoP Data

I found that domain and taxonomic analysis were kind of two "stages" combined into one iterative one. One (albeit small) category that emerged was setting realistic, achievable goals. That made me think that one of the reasons that the Mulberry CoP wasn't successful was because they tried to do too much.

Memo 11: Order of Coding

Since most of the Firefly CoP's raw data was coded first (everything except the CoP documents), it was the primary basis for interpretation that lead to the emergence of the results. Therefore, since the Mulberry CoP's data was coded after that of the Firefly CoP, there were several codes and categories that seemed to fit with categories and codes already derived from the Firefly CoP. However, I still paid attention to any completely new categories or ideas emerging through the Mulberry CoP data. Since this is a constructivist study, it is important to acknowledge that there are various possible interpretations of the data. The interpretations presented in this study are merely mine (with some input from my supervisor and committee members). Therefore, it is entirely possible that a different interpretation and hence different themes may have emerged if the primary analyst has been a different individual or if the Mulberry CoP data was coded first.

Curriculum Vitae

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